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Fascinations and Frustrations

HUNDREDS OF farewell parties were held all over Canada in recent weeks as Mary or Joan, Helen or Dorothy prepared for the big adventure — to become registered nurses. To the school of their choice, in any one of the dozens of cities across Canada, the girls have flocked to begin their classes, to wear a nursing school uniform for the first time — the first step in satisfying their urge to "help people," the most commonly given reason why girls enter training.

Most of them are only 18 years old. Eighteen years *young!* From the lofty eminence of two, five, ten, twenty-five years of nursing experience — and in some instances, disillusionment — we watch these girls with their fresh complexions, their glowing interest, their eager enthusiasm. They have had a dream, a fascination, about "white-clad beings who moved through indefinite days and nights with nothing more strenuous to do with their hands than smooth fevered brows." They know that kindness, patience and similar admirable virtues are essential attributes and sincerely believe they possess them. They realize that training and the acquisition of suitable skills are necessary so that they will know what to do in order to minimize pain and help to restore patients to health. What they do not realize at first, perhaps, is that there will be days of such complete frustration that they will yearn for home and the feeling of security they always found there. There will be black days when the anxieties and perplexities of their new life seem almost overwhelming. Occasionally, the flood of longing for the less complex existence they have left will prove too strong and some will withdraw from the school.

How can we help *all* of these girls to learn to adapt themselves successfully to the fascinations and the frustrations alike? Is there some new approach that has not been tried in too many of our schools of nursing to assist these able young students to reach the degree of emotional maturity that is so essential for every woman and is especially vital in graduate nurses? Would the addition to the staff of a *qualified* counsellor — not necessarily a nurse — be of positive assistance? Can we, somehow, increase the fascination of nursing and

at the same time diminish the frustrations so that the graduates of tomorrow will look back on their periods of training with sincere appreciation as most valuable personal and professional experiences.

Many writers have suggested answers to some aspects of these problems. We have two answers in this issue. We hope every graduate and student will read Miss Rae's article, "My Need" and then turn to Sister M. Cecil's article for further guidance.

There are some other thoughts that are worth-while considering. The first is a matter of terminology. Is the place in which the students live called a "residence" or a "home"? It has been our privilege to visit most of the schools of nursing in Canada and in too many instances we have been shown over the "residence." Dictionary definitions portray the subtle difference in the two terms: *residence,* "place of abode"; *home,* "the abiding place of the affections," "the social unit formed by living together." The first is cold, formal. Some student nurses live in places like that! The second is intimate, personal — the longed-for goal of most people. Let us refer to them as "nurses' homes."

Then we should go much further and endeavor to make them as truly homelike as possible. What is to be found in the homes from which our students have come that is missing in the buildings provided to house them when they enter training? Skipping over the matter of the personalities involved, the privacy that is inherent in single rooms, etc., there is one colossal difference that deserves special attention. *At home there was always room for them to develop and explore their own hobbies.* At the hospital, most students forget that they ever had any skill or interest in handicrafts, in collecting, in musical instruments, in sport. Sitting-rooms are provided where visitors may be entertained but what provision is made for a place where Mary can set up her loom and have relaxation in weaving; where Joan can work on her precious stamp collection; where Helen can continue the practice that her promising voice deserves; where Dorothy can swim? All of these are possible if somebody takes time and thought to arrange for hobby rooms or makes special provision for the school's night at the local Y.W.C.A.

The students themselves have furnished another answer to the acute sense of detachment these girls are so prone to feel on their first serious venture from home. Suggestions were made under this heading in Miss Farquharson's report last month of the Student Buzz Sessions.

These are a few of the possibilities. None of them calls for the expenditure of vast sums of money. Each does demand some thought and some planning. Perhaps provision of hobby facilities is the most expensive. Let us hear, through these pages, what is being done to open the doors to the developmental interests of the hundreds of would-be nurses who are included in the class of '57.

Universities Approve Fluoridation of Water

Unequivocal approval of community fluoridation of water supplies for the prevention of dental caries has come from 63 Canadian and American universities. The Health League of Canada approached departments of preventive medicine in the universities in a survey conducted at the request of the Canadian Federation of Mayors and Municipalities. A special committee of physicians and dentists conducted the study.

Canadian universities endorsing fluoridation included Saskatchewan, McGill, Toronto, Queen's, British Columbia, Montreal, Western Ontario and Laval.

United States universities included Harvard, Yale, Johns Hopkins, Columbia and Stanford.

While this survey was being conducted the Canadian Medical Association, in annual meeting at Vancouver, also endorsed fluoridation, adding its support to that of medical, dental, and public health authorities throughout the United States and Canada.

— *Saskatchewan Health Newsletter*

Nursing and Canada's National Health Program

PAUL MARTIN

IT IS A GREAT PLEASURE for me to have the honor of delivering the keynote address at this 27th biennial meeting of the Canadian Nurses' Association. This association is dedicated to the improvement of conditions for the nursing profession and, more important, for the public it serves. By keeping abreast of all the latest developments in the field of nursing, it helps its more than 30,000 members in keeping true to those ideals of sympathy, understanding, patience and commonsense that, for so many years, have been the hallmark of the Canadian nursing profession.

I shall speak later about the nurse's vital role in Canada's health services and about some of the problems now facing your profession. I shall have something to say about what the Federal Government — in cooperation with the provinces and with this association — is doing to help strengthen the nation's nursing resources.

POLIO VACCINE FOR CANADA

First, however, I should like to say something, through you, to the people of Canada, about an increasingly serious health problem of interest to every Canadian nurse. I refer to poliomyelitis, which, in this country, reached an all-time high last year of 8,734 reported cases.

A great deal of public and professional interest is now centred on the important research study being undertaken in the United States this year to determine the effectiveness of a newly-developed polio vaccine. In Canada, the Federal Government, in cooperation with the provinces, is giving the most active consideration to ways and means of ensuring that substantial quantities of the vaccine will be immediately available for use in this country just as soon as its effectiveness has been confirmed.

Since there is a considerable amount of understanding on this question, it should be made clear that, as yet, there is no known permanent immunizing agent against polio that has been adequately tested. A vaccine that seems promising has been developed by Dr. Salk of Pittsburg and is being made up for the U.S. National Foundation for Poliomyelitis from polio virus produced largely in Canada. During this year's polio season, the Salk vaccine is being tested on scientifically selected sample groups of some 500,000 children throughout the United States of whom approximately one-half will receive the vaccine while the others are given a neutral solution for comparison.

It should be emphasized that this is not a general immunizing program but rather a scientific experiment carried out under carefully controlled conditions in order to test the effectiveness of the vaccine. *Any widespread use of the vaccine as an immunizing agent must await the results of this trial which should be known late this fall.*

The cost of the lifetime medical care of a severely paralyzed child has been estimated at upwards of $40,000. But its cost in human terms is infinitely higher still. Only the nurse who has watched the heart-rending sight of a child lying day after day — for one, two, three years — in a mechanical respirator on which he depends for breath and life, can know what it would mean to find some effective method of combatting poliomyelitis. Only the parent who has known the bitter tragedy of having polio strike — swiftly and without warning — can fully

Mr. Martin is Minister of National Health and Welfare, Ottawa, Canada. This address was delivered at the opening of the 27th Biennial Meeting of the Canadian Nurses' Association in Banff.

appreciate the extent of human suffering that could be avoided if some way were found of preventing this crippling and killing disease.

Canadian Participation

When the National Foundation for Poliomyelitis first announced its intention to initiate this year's experimental study, there was some doubt as to whether a sufficient supply of the vaccine could be made available in time — not because of any delay in the Canadian production of the virus from which the vaccine is made, but because of the need for extensive testing of the finished product to ensure its complete safety.

Late in April it was found by officers of the Polio Foundation that, happily, supplies would be adequate for their study and, indeed, that there would be a quantity of the vaccine surplus to the requirements for the current trial. Because Canada had had such an important part in the preliminary research and development and in the manufacture of the vaccine, it was suggested that this surplus quantity might be made available to this country to be used experimentally along the same lines followed in the United States — as an integral part of the American trial. This offer, however, left little time to set up the necessary machinery for the carrying out of a successful trial, bearing in mind that a number of injections must be given over a period of several weeks and must be completed before the onset of the polio season.

Although we recognized the difficulties that would be involved, the Federal Government communicated with the ten provincial departments of health indicating that the Polio Foundation was prepared to make limited supplies of the vaccine available to any province wishing to participate in the study. As a result, the vaccine *may* be used experimentally in certain areas of Canada this summer. It should be re-emphasized, however, that any use of the vaccine in Canada this year will not be a general immunization program but rather an extension of the trial already begun in the United States to determine the effectiveness of the vaccine. It should also be stressed that the sample group selected for the study in the United States is already sufficiently large to produce scientifically valid results and Canadian participation in the experiment is not expected to alter its findings appreciably.

The important thing is that this country should be ready to take full advantage of the vaccine immediately its effectiveness has been confirmed.

Gamma Globulin

In the meantime, in cooperation with the Canadian Red Cross Society and the ten provinces, the Federal Government is this year supporting a greatly expanded program of gamma globulin inoculations. The production of this blood fraction — which has been shown to provide a temporary immunity against polio if given at the right time and in the proper dosage — will be more than doubled this year and provision will again be made for its purchase out of federal health grant funds for distribution to all provinces.

I have dealt with this matter at some length because of its great public importance and because of the vital interest every Canadian nurse has in the prevention and treatment of polio. I want to assure this audience and the people of Canada that the Federal Government will continue to play its full part in ensuring that the people of this country will enjoy the benefit of any outstanding advance in the prevention of this dread disease.

New Federal Grants for Nurse Training

Now, to turn to some of the more immediate concerns of Canadian nurses. It is no exaggeration to say that at no period in Canada's health history has greater recognition been given to the importance of nursing. I have opportunities every day of observing at first hand the vital role played by nurses in so many areas of health care. The Department of National Health and Welfare recognized this fact by appointing a full-time consultant on nursing services, Miss Dorothy Percy, whose outstanding work is well known to the

members of this association. In Miss Evelyn Pepper, we are also fortunate in having a well-qualified expert to advise on the most effective utilization of nursing skills in our developing civil defence organizations.

In planning its National Health Program, which was inaugurated six years ago, the Federal Government recognized that the trained nurse is basic to the success of any worthwhile health plan. For this reason, particular attention was given to developing ways and means of increasing and strengthening the nation's resources of nursing personnel.

I am happy to announce an important change in the terms of the Hospital Construction Grant which will provide for substantial federal assistance towards training facilities in hospitals. In future, matching grants will be available on the basis of $1,000 for every 300 square feet of approved floor area towards the construction of necessary additional training facilities contained in or connected with a hospital, such as classrooms, auditoria, demonstration rooms, and so on.

This extension of the Hospital Construction Grant should help materially in increasing the supply of graduate nurses. At present, many of the larger nursing schools have *more* applicants than they can accept with their existing facilities. The new grants will help in developing additional facilities so that larger classes can be accepted. On the other hand, the smaller nursing schools with less adequate facilities frequently have *fewer* applicants than they are able to accommodate. The improvement of their training facilities should serve to attract more applicants.

Already, under the National Health Program, much has been done by way of bursaries, the provision of training equipment and the employment of instructional staff to assist in the training of nursing personnel. Let me just review a few highlights. During the past six years:

Federal grants of more than $3,000,000 have been provided towards the cost of constructing nurses' residences to accommodate upwards of 6,360 nurses.

Bursaries and scholarships have been given to more than 3,100 nurses selected by provincial authorities for special training.

Federal grants have been used to provide staff and training equipment for post-graduate nurse training facilities at a number of universities and large hospital nurse training schools.

Grants of more than $260,000 have underwritten two experimental accelerated training courses at Toronto Western and Windsor's Metropolitan Hospital — the latter sponsored by the Canadian Nurses' Association.

Training schools for nurse aides have been set up with federal support at a number of Canadian centres, including Montreal, Fort William, Sudbury and Calgary.

In addition to the very substantial assistance provided to nursing under the National Health Program, the Federal Government has made special provision under the Vocational Training Grants administered by the Department of Labor, to provide assistance to undergraduate nurses who are unable to proceed with their training without financial help. This scheme, which is administered in cooperation with provincial authorities, provides for grants or loans up to a maximum of $200 on the understanding that, following graduation, the nurses will serve in public health work, approved hospitals or similar institutions.

Last year, nearly 700 nurses in training benefited under this scheme with federal contributions amounting to some $20,000.

The Widening Scope of Nursing Service

In the century since Florence Nightingale first won public recognition for the vital work a nurse can do, nursing has grown from simple bedside chores to become a complex, highly specialized and very demanding profession. The graduate nurse of today is expected to perform with faultless precision more intricate and more responsible treatments than those undertaken by physicians a century ago.

Even 50 years ago, the limits of the nursing field were rather narrowly defined. The graduate nurse at that

time might have joined a hospital staff, gone into private nursing, worked in a doctor's office, or perhaps joined the newly-formed Victorian Order of Nurses which has since contributed so magnificently to public health progress in this country. These alternatives pretty well exhausted the possibilities open to a nurse at the turn of the century.

Today, the prospect is completely changed. The graduate nurse can still join the staff of one of Canada's excellent hospitals. She can still engage in private nursing, become a member of the V.O.N., or work in a doctor's office. But above and beyond these prospects, there are all kinds of new and interesting possibilities. In all parts of the country nurses are required for public health work. In rural health units, in urban and provincial health departments, nurses must staff essential health services. Here I might note that while public health requires the services of a great variety of professional workers, the nurse is at the very heart of public health work. It is through the public health nurse that services are taken right into the homes of the Canadian people.

In industry, too, there is an ever-widening expansion of occupational health programs which require the services of specially trained nurses. Miss Mildred Walker is my valued adviser on developments in this important field.

In government departments, at every level, there are many opportunities for service open to nurses who have an interest in public health work. For example, we are always looking for nurses of the right kind to staff our far-flung Indian Health Services. I understand that Miss Alice Smith, the Department's Chief of Nursing Service for Indian Health, will be participating in one of the panel discussions later in the week.

Nursing and Civil Defence

In Canada's developing civil defence program — which has taken on added urgency in recent months — nurses of all kinds have a vital role to play. The Federal Government has provided special instruction to 1,330 key nurse instructors who have passed on this training to 28,000 individual nurses across Canada. It is particularly gratifying to me that *no less than six provinces have incorporated civil defence instruction in their basic teaching for student nurses* so that their nursing personnel will be well-equipped to shoulder their important responsibilities in the event of any future emergency.

In October, 1952, at the request of the Canadian Nurses' Association, a survey of the nursing resources of the province of Manitoba was carried out primarily for civil defence purposes. This study was undertaken by the provincial planning group for civil defence health services in cooperation with the Provincial Department of Health and Public Welfare, the C.N.A., and the Department of National Health and Welfare. The objective was to enumerate all nursing personnel, whether active or inactive and to establish a provincial registry based on the information obtained.

This was the first attempt ever made to reach all nurses, whether active or inactive, and should provide a useful pattern for similar surveys in other parts of Canada. I understand that the information gained from this survey was most helpful in mobilizing the province's nursing resources to combat last season's polio epidemic in Manitoba.

Pathways to the Future

A second nursing study carried out by the Department of National Health and Welfare has aroused much interest among hospital administrators and superintendents. I refer to the Head Nurse Study conducted at the Ottawa Civic Hospital in order to obtain a description of the functions and activities of a head nurse in a general hospital. This, we hope, will serve as a valuable guide in planning for the most effective use of nursing resources in the interests of the patient.

We hear a good deal these days about the shortage of nurses. Undoubtedly there is a serious shortage

in certain areas of service, particularly in the field of tuberculosis and mental health, and in certain parts of the country. But in overall terms, Canada's average ratio of nurses to patients is one of the most favorable in the world.

It is repeatedly said that 20 to 30 per cent of the girls leaving high school with the qualifications necessary to enter an approved nursing school actually do so. Labor experts suggest that, with the many careers open to young people today, this proportion is all that can be expected if teaching, business, and other areas of service are not to suffer from lack of personnel.

In addition, the low birth rate of the depression years is now reflected in a lowering of the number of girls in the proper age groups to enter training. In these prosperous times, the high marriage rates, the tendency to marry at an earlier age, and the attractive terms of employment in other fields requiring less preparatory training, have all conspired to lessen the number of young women entering nursing as a career.

It seems to me, however, that our problem today is not only one of increasing the supply of nurses but of re-appraising our nurse training programs in the light of the growing complexity of nursing and re-assessing our utilization of existing nursing resources. These are problems that will be much to the fore in the discussions of this convention which has chosen the appropriate theme — "Pathways to the Future." It is a sign of progress — both in individuals and in organizations — to possess that restless instinct that urges us ever on to new, though sometimes distant, goals.

Today, all across Canada, many new developments are making the profession of nursing more interesting and more challenging than ever before. But with all the advances of medical science we should remember that the most important ingredient of nursing service is not technical knowledge or professional skill, however necessary these may be, but a kindly and sympathetic approach to the patient as a human being in need of understanding care.

Nursing is an essential part of health care, which today is as wide as the reach of the human mind and as complex as the shape of our society. As Canada's nurses seek out the pathways to the future, perhaps the heroic figure of Geneviève de Galard Terraube, caring for the wounded in the doomed fortress of Dien Bien Phu, will serve as an inspiring reminder, an abiding symbol of those values that have come to be so closely associated with the work of this time-honored profession.

Medical treatment needed by young women with heart disease who want to have children should "logically begin in the period before marriage," according to Dr. Burton E. Hamilton, consultant in cardiology to the Boston Lying-in Hospital. Since successful pregnancy for such women "depends in part on planned living and cooperation from the patient's family, timely education for all concerned is needed." If surgery appears necessary, for example, to repair damage to the heart valves caused by rheumatic fever, or to correct congenital heart defects, it is preferable to undertake it in advance of pregnancy.

The majority of young women with heart disease are not seriously handicapped by their condition and can expect to bear children successfully, according to Dr. Hamilton. He calls this majority the "favorable" cases and says that the mortality rate goes up only slightly in this group as a result of becoming pregnant. This is true, he emphasizes, "only if the pregnant patient seeks and receives proper care." Otherwise she runs nearly as great a risk as if she were among the small minority of heart patients whose condition is poor. For those severely handicapped, "the unavoidable load of pregnancy leads to a high maternal death rate even with the best of care." Adequate prenatal attention also has a "powerful, beneficial effect" on the survival chances of the babies born to mothers with heart disease, and makes for an infant mortality rate hardly any higher than that among the general population.

—*American Heart Association*

Closing Thoughts on the Convention Theme

MALCOLM G. TAYLOR, M.A., Ph.D.

IT WAS WITH GREAT INTEREST that I observed your deliberations this afternoon, as you took steps towards the establishment of what, in political science, is referred to as a strong federal union, as contrasted with the looser type of organization that is called a "confederation."

The action you have taken stirs the memory of great historical events of the past. In 1787 a group of statesmen from the new American states gathered in Philadelphia to find ways and means of preventing their confederation from falling apart. Four years before, as a collection of states, they had won complete independence from England. To wage that war and to conduct their other external relations, these states had formed a loose confederation but now, the war over, the stimulus of an external enemy gone, they were as 13 separate nations, going their own ways, waging, in fact, a "cold" war upon one another. Out of those deliberations at Philadelphia, the American federal union was conceived, and in 1789 it was born. Out of that bold experiment there grew a nation destined to become the leader of the Western world.

In the 1890's a similar problem faced the British colonies on the continent of Australia. Again, the desirability of unified action, the necessity for merging common interests into one national body became so evident that its acceptance led to the formation of another strong federal union whose voice and influence in world affairs far exceeds anything that might have been forthcoming if those six colonies had gone their separate ways.

Dr. Taylor is assistant professor of Political Science, University of Toronto. This address closed the 27th Biennial Meeting of the Canadian Nurses' Association at Banff.

Coming closer home, in the 1860's as the flames of civil war in the United States threatened to engulf the remaining British colonies in North America, statesmen of Upper and Lower Canada and the Maritimes saw the need for closer union and, as a consequence, our great Canadian federation was created.

I need not stress the parallel between these events and your actions today. Although I know that you would not suggest that these four events are of equal historical significance, nevertheless, certain parallels may be drawn that it might be helpful to note.

First, and most obvious, is that in union there is strength. You will be stronger because you will be more closely united. By mobilizing your resources, concentrating your leadership and harmonizing your voices, you strengthen your profession and thus make it more possible to attain your great humanitarian goals.

Second, while you pool your resources and unite your efforts, you do not obliterate your individual provincial personalities. You retain your individual identities, the special traits, abilities, characteristics, customs and spiritual qualities that have identified each of you as provincial bodies. These you do — and must — retain; and not merely retain, but nourish and develop, for these are the well-springs of inspiration from which you replenish your intellectual and spiritual resources at the national level.

Third, like the founders of the three federal experiments that I have mentioned, I am sure that you are building more greatly than you know. Madison, Deakin, or John A. MacDonald, with all their vision, could not have foreseen the great achievements in free self-government that their statecraft helped to set in motion. Each of these federa-

tions has spanned a continent, and provided the type of environment in which, with the sole exception of England herself, the fires of freedom, in the light of which men and women develop their ideas and their creative talents, burn more brightly than anywhere else.

Whether the pathways to the future be straight or tortuous, I believe you are building an organization — a vehicle, if you will — that will enable you and your successors to reach heights of accomplishment not yet visible. This is a milestone in Canadian nursing progress. I congratulate you on your statesmanship. I look forward, with you, to greater achievements in the future.

It was the year of the American Declaration of Independence, 1776, that Thomas Paine wrote, "These are the times that try men's souls." I suppose that every generation since then has felt that the description was equally true of its own day. You and I would agree that it mostly aptly describes this mid-period of the 20th century.

This century, as has often been pointed out, is a period of change and transition so rapid that time, like geography, seems to have been telescoped. The pace of our daily living, our association with our co-workers, our relationship to the community, our patterns of thinking as we are constantly bombarded by skilful propagandists operating through the mass media of communication — everything we know is being constantly subjected to change and modification.

One of the consequences of this change that frequently seems to threaten us as individuals, has been the rapid growth of associations. Through the group we strive to achieve a goal or to find a degree of security that does not seem to be attainable or assured to us as individuals. These associations are of many kinds and are formulated for a multitude of purposes: trade unions, employers' councils, trade associations, farmers' associations, cooperatives, municipal associations — right up to the United Nations.

Among the oldest associations are the organizations of the professions — law, education, nursing, medicine. These differ from other associations in a number of ways,* including (a) the possession of a complicated skill requiring the exercise of judgment in its application to varying situations; (b) a usually long period of careful education; and (c) a skill that is usually marked by devotion to the service that is rendered rather than to the financial reward. Nursing, as one of the professions, is characterized by its "devotion to the successful rendering of a service." Because our society recognizes this distinguishing characteristic, there is a dignity surrounding the professions, and a respect accorded to them by society in a degree not granted to others. At the same time, society also expects in return for this greater respect, correlative obligations, including the obligation of giving leadership — leadership for which the profession is equipped by reason of its specialized knowledge and skill.

It is not easy to meet the expectations of professional standards in any profession. It is much more difficult in the professions of teaching and nursing where substantial numbers of the members enter the profession for only brief periods of time. Their aims may lie primarily outside the profession, their satisfactions in other than professional service. For these, the effectiveness of the period of training and education in inculcating the ethos and ideals of the profession will be paramount. The difficulties grow greater in an age of materialism and commercialism. The responsibilities grow more complex in a period of great change.

The changes that affect your profession are not only, as you are so profoundly aware, in the area of scientific discovery and in the technique of medical and nursing care, but equally so in the organization and financing of health services. The trend of population to the cities, modern living in small apartments and houses, a growing proportion of the population dependent on wages, a weakening of

* Herman Finer, *Administration and the Nursing Service*, p. 10.

family responsibilities — all these, added to the increased costs of modern medical and hospital services, have created a virtual crisis for the individual family in meeting the costs of health care.

The resulting developments to meet the economic crisis have been phenomenal. Ideas, suggestions, schemes, plans, proposals and counter-proposals pour out in a veritable stream. A specialized field of knowledge has been developed, called "medical economics" in which, as one writer said of experts on Russia, "There are no experts, only varying degrees of ignorance." Experts or not, the problem is being tackled, the field is literally in ferment. The concept of insurance or prepayment has been introduced and, while not new in itself, its application is relatively new in North America. In fact, most of the development in Canada has occurred since 1940. One can distinguish several types of programs now functioning:

1. The Blue Cross plans providing prepayment in-patient hospital care.

2. The profession-sponsored medical care plans providing coverage for either a comprehensive range of physicians' services including home and office calls, or a more limited range of benefits covering medical or surgical care in hospital only.

3. Cooperative-sponsored plans providing either medical or hospital services or both.

4. Commercial insurance companies providing indemnity contracts covering medical and hospital benefits and, if desired, in combination with other types of insurance.

5. A number of industrial plans.

6. Governmental hospital or medical care plans:

(a) Four provinces — British Columbia, Alberta, Saskatchewan, and Newfoundland — provide hospital care benefits available to a part or all of the population.

(b) The Swift Current Health Region in Saskatchewan provides a comprehensive medical care plan for all residents.

(c) Five provinces — British Columbia, Alberta, Saskatchewan, Ontario and Nova Scotia — have established either comprehensive or limited medical care programs for recipients of public assistance.

About 5½ millions are covered by the non-governmental hospital plans and about 2¾ millions are covered by the government hospital care plans. Approximately 4 million persons have some protection against the costs of medical or surgical care. Nearly 300,000 persons are covered by the governmental programs for recipients of public assistance.

This development has not yet embraced prepayment for private nursing services although, in a serious illness, round-the-clock private nursing may constitute the largest single item in the medical care bill. This is a problem area which needs immediate study and solution. As I understand it, the problem is chiefly administrative rather than financial. In those few plans where private nursing fees are paid, the premium for such insurance is not great. But the administrative task of deciding the degree of necessity for private nursing when the insurance agency pays for it is fraught with difficulty and almost certain to arouse ill-feeling on the part of physician and patient when payment is refused. As one administrator has remarked, "When our plan paid the nursing bill, every patient seemed to need a private nurse."

Although the adoption of prepayment of medical and hospital care has spread rapidly, it has not done so without controversy and difficulty. Scores of important questions have been asked:

Should it be voluntary or compulsory? Should insurance be total or partial? Should doctors and hospitals control the plan or should the public, which pays the bill, control? Is there a middle way in which both participate? Are these plans to be available only to persons who can be enrolled in groups? If not, how is the individual not in a group to be covered?

Should a subscriber, enrolled through his place of employment, be able to continue his insurance protection permanently or should he lose it if he transfers to another employer where the em-

ployees are not insured or if he retires? Should the insuring agency pay the bill directly to the doctor or hospital, or should the patient pay the bill and be reimbursed?

Should these plans be contributory, that is, should the subscriber pay all the premium, or should the employer pay part or all? Is there any difference between subsidization by an employer of a voluntary plan and subsidization by government in a governmental plan? Who should subsidize those not having an employer?

In addition, there are problems of control that arise inevitably when a third agency enters into the financial picture.

With costs to the individual patient no object, who controls unnecessary services, for example, unjustified admissions, unnecessarily prolonged stay, or indiscriminate prescribing? People who are insured have 75 per cent more operations than people who are not insured. Is this the real measure of need? Why, with modern therapy, has not average length of stay in hospital dropped more rapidly?

If the insuring agency is aware of over-utilization, what steps can it take? What positive steps can prepayment agencies take to assist in improving the quality of medical and hospital care? What steps can we take now to see that the advantages of prepayment are available to all?

The asking of such questions may suggest unwarranted interference in the providing of services, but it should be clearly understood that the asking and answering of these questions is inescapable. The mechanism of prepayment, together with our attitude of generosity in meeting the needs of the sick, is in conflict with the economic reality that our health resources are limited. If, through health insurance, whether voluntary or governmental, we aim to provide all the health services that the patient needs, we must be certain that they are what he needs but no more. This is a challenge to the administrative capacity and the professional integrity of all the health professions and hospitals as well as to the insurance administrators.

But even this will not be enough. The demand for health services will continue to rise, first as a component of a rising standard of living for all of us, and second, as a result of our aging population with its changing pattern of illness requiring long-term treatment.

The expanding needs will place increasing burdens on all individuals and agencies providing health services — and not least on the nursing profession! This, next to establishing an effective international organization to keep the peace, constitutes the greatest single challenge to our ingenuity in social organization. Part of the problem arises from the rapid growth of the voluntary and governmental hospital care plans. By solving in large part the economics of in-patient care in general hospitals it has naturally followed that, whenever an illness presented itself in which hospitalization was among alternative types of suitable care, it tended to be the one selected because it was the one for which the patient had already paid.

In other words, the acute general hospital has been called upon to assume responsibilities for a volume of in-patient care far in excess of what it should be handling. This is not only bad economics, but, as I have been given to understand, it is not always the best treatment from the patient's point of view. Because most of you are involved in hospital care, since you are, in fact, the pivotal service in hospital care, this is in large part your problem. But, like most of the problems in the health field, no one group can solve it alone. The first step must be, it would appear, the establishment of community-wide, province-wide and, for certain purposes, nation-wide planning agencies with representatives of all the health professions, of the public, and of government, who will continue and develop the planning job begun by the Health Survey Committee established under the Federal Health Grants program. Some of these provincial committees needed to be more representative. Moreover, it should not be thought that this is a purely provincial or federal matter. Health councils are required at the local level where needs

can best be measured and solutions adapted to local situations.

A second step must be to solve the twin problems of providing out-patient radiology and laboratory services as well as establishing methods of paying for them on an out-patient basis. Steps in this direction have already been made by the new Federal Health Grant for radiological and laboratory services but there has been little evidence of its widespread use by the provinces.

A third step must be the establishment of proper facilities for long-term illness and the provision of some better methods of financing long-term treatment than we have thus far achieved. Must it continue to be our philosophy that not until the financial resources of the patient and of his family are completely exhausted do the resources of the community come into play? Must there always be added to the catastrophe of illness the catastrophe of indigency? Surely it is neither in the interest of the individual nor of society that we handle this problem in this way. Surely we can do better than this.

The fourth step, as I understand the problem, must be the utilization of all the extra-institutional services that we can. This also affects you for it means the provision of services in the home. Granted that there are difficulties in the administration of home care programs, there is sufficient experience now in several programs in the United States and in the great work of the Victorian Order of Nurses throughout Canada to show that in many cases this is a feasible method of providing quality care in the patient's own surroundings at substantial savings in resources. Extension of services in this area seems imperative. On all sides one hears comments that something must be done along these lines. Why are we waiting for someone else to begin?

There are probably other types of programs which need to be developed, but, to the uninitiated outsider, these seem to be among the areas of special interest and special challenge to the nursing profession.

It also seems to me that you cannot afford to evade the challenge. I know, of course, that you are not evading it. There is evidence of real leadership from your profession in solving these problems, but I think you must do more, for your interests and for the community's interest. Unless you participate in the long-run planning and development of such programs, the decisions about your role will be made without you. This, I am convinced, will be detrimental to the programs and, ultimately, to you. For others, I believe, are too prodigal — too wasteful — of your services. I fear, that even some of you approach these problems with a depression-born philosophy, that nurses must do everything in sight or there won't be enough for nurses to do. That time is past!

It is now necessary to conserve our professional nursing resources and use nurses only where their specialized knowledge and skill are essential. This applies not only in new programs and services. It is most important, nay, it is absolutely essential, that you examine your present pattern of practice and organization of nursing services in hospitals, clinics, public health, or wherever else you may serve, to make certain that you are performing your proper function. Every job analysis of nursing services has shown you serving as admitting clerk, ward secretary, errand boy, telephone operator, housekeeper, in addition to your nursing care. As we wrote in the Saskatchewan Survey of Nurses, "the nurse is being called upon to perform tasks for which she has been over-trained, under-trained, or not trained at all."

By freeing the nurse from these non-nursing tasks, there should be more time available for nurses to give that tender loving care that patients now so frequently complain they no longer receive.

This re-examination of current practices, this seeking of new techniques, this assuming of new responsibilities while delegating old ones to other types of workers, the inevitable uncertainty as one pioneers new fields, the necessity of forming new relationships as there is developed a team approach in health care — all of this is exciting, stimulating and challenging.

It is also disconcerting to those of us who like to maintain our established practices. It is not easy for any group to adjust to new circumstances, but for you it appears to be even more difficult for, while all else changes about you, one factor must remain constant, that understanding relationship with your patient. It must not be impaired; it must only be enhanced.

As I have surveyed these areas of need and suggested the direction which new developments are likely to take, your automatic response is likely to be, "But hasn't he heard of the shortage of nurses? How can we expand and develop new programs when we haven't enough nurses to perform the tasks we are called upon to do now?"

This is part of the whole task of the re-examination of current practices that is so essential. The nursing profession, having developed its technical skills to the stage where demand for those skills outruns the supply, must become equally knowledgeable and skilful in the area of scientific management and administration. I may be prejudiced because my primary field of instruction at the University of Toronto is public administration but, if illustration is needed from a related field, it is worthy of note that it is only about a dozen years since hospital administration became a special course of professional training. No one would now doubt that the training of professional hospital administrators and the development of a body of literature in hospital management has had a most salutary effect on efficient provision of hospital services.

If this be true for the hospital as a whole, it is equally true for the large and complex nursing service. Some of you are already aware of the contribution that scientific management can make; some of you are already convinced of it; some of you are already acting on that conviction. I venture to say it will not be long before the science of administration will have taken its place along with the biological science in the curriculums of all schools of nursing. Whenever it comes, it is overdue. You and the hospital and the patient will be the beneficiaries of the contribution that scientific management, applied to nursing service, can bring.

All of the suggestions and the developments that I have mentioned up to this point are of concern to you as members of one of the great professions. Individually and collectively you will think of these problems, and individually and collectively make your contributions felt. But you are not merely members of a great profession; you are citizens of communities, of provinces, of a nation, and the nation is one of many. The country of which you are a citizen is a democracy, and at this present juncture of history, democracy is everywhere on trial. If democracy is to flourish, then the needs of the people who compose that society must be met. The spirit of democracy — to flourish — requires alert, intelligent and responsible citizens — citizens who will individually and through their organizations participate in solving the problems of their communities — local, provincial, national and international.

In other words, the leadership that you display here, in your provincial associations, and in your local chapters must not be confined to those organizations alone — the community and the province and the nation have need of women of your calibre with your humanitarian outlook.

The pathways to the future are only dimly seen. The direction that we should take is often clouded by ignorance and lack of understanding. The issues that present themselves for decision are often obscured by alien philosophies and by those who seek to serve their own selfish interests rather than the interest of humanity. All about us is the need for the light of understanding of the problems, the need for the penetrating light of intelligent thought, the need for the enlightened application of reasonable solutions, and all done in the warm glow of sympathetic appreciation of the human needs involved. Who better, I ask, can shed this light than the lady with the lamp?

My Need

LYNE RAE

MY NEED SENT ME SCUTTLING to the many books of wisdom! As I read, re-read, and pondered I came to realize that more was involved than I had anticipated. I found that practically every psychologist had a different theory about this basic need of resolving objective anxiety or tension.

I learnt that what I had supposed to be my own peculiar need was actually an area shared by everyone; that the normal individual uses these periods of objective anxieties, or tensions, as "learning experiences" and then by using deliberative action can progress forward in his development. This conclusion set me thinking and exploring into myself. Was I really learning and progressing through these experiences or were these situations on the verge of causing disruptive results? To add to the confusion I became completely perplexed when I read that the more creative the individual happens to be the more he is confronted with anxiety. Now, where was I? I thought I was being creative through the medium of music to relieve tension, only to learn that this could cause *more* tension or anxiety! This lead me to further searchings.

What insights have I gained by reflective thinking, based on my readings, studying, and observations of myself? After delving into Freud, Horney, May, and others I have decided that Horney and May come the closest to the core of the cause of my anxiety, particularly at the present time. They stated that anxiety or tension is a form of a threat to some value which the individual holds essential to his existence as a personality and that it can be an underlying threat of losing the bond of relationship to significant individuals. In the child it is the parents with whom the bond may be lost, while in an adult it may be the group.

Miss Rae, who comes from Winnipeg, wrote this paper in the course of pursuing post-graduate university studies.

As I thought this through I began to gain insight into myself. The seat of my anxiety, without a doubt, was the threat of not succeeding in my studies. This would have hurt my pride and I would have lost prestige among my friends and fellow-workers. I had had to obtain financial aid to make it possible to further my studies, therefore I felt that I had a responsibility to others to do well.

Anxiety is also caused from the threat to the value of the opportunity of being at college. This, I felt, was the basis of all the anxiety situations produced by my studies and work in the college. Every assignment and every examination carried to a smaller or greater degree a threat to this value.

My next step was to explore the possibility of resolving some of this tension through recreation. Would it be possible, through recreation, to express unconscious drives and to release physical and emotional pressures? I found that the choice of recreation is related to inner tensions and to character structure. It can serve as an escape from reality or it can be used resourcefully for a period of solitude. Through recreation the individual seeks to satisfy some inner road.

By now I was well on the road. I had read what the authorities had to say about objective anxiety and I had found that I was a perfectly normal human being. I had learnt that recreation would aid in relieving some of the emotional tension. I had learnt that mild tension could be used constructively as a learning experience to grow and develop.

I was ready to proceed further. The next question to be solved was — can music as recreation act as a means of resolving some of my emotional tension? Was it going to give me an opportunity to be creative? Would the tensions be aggravated? I answered these questions through observations of myself and through study. One of the authorities stated that music was

an expression of one's inner feelings and if these feelings could be expressed outwardly through the making of music the individual would feel that much better. All emotions, moods, aspirations, hopes, and fears have been expressed in music so that the individual has the power to arouse in himself the most joyous and noblest emotions. I have found this to be very true. There have been some days when I have felt harried and so hard pressed for time that I hesitated to go for an hour of piano practice, but I have persisted and observed the reaction. Each period has been beneficial and profitable because, as I returned to my study, I found that I was refreshed and better able to concentrate on the problem at hand. Tension was relieved.

I have found music-making a challenge. Through it I can recreate or attempt to recapture part of the experience or emotion which impelled the composer to write that piece of music. Creative work, no matter how elementary, is more important than passive appreciation. It is giving me an opportunity to develop skills and knowledge in another field. Even more important, I am forming new bonds of relationship with other people.

Leaving college will not automatically eliminate all my anxieties or tensions. All through life we are faced with situations that cause tensions. I feel that in the future I will be better able to analyze my tensions to find the cause and I will be better able to use recreational methods to ease and grow through these situations. With this paper completed, I will relax and vent my feelings of tension on the piano!

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Hardening of Arteries not Inevitable

IT SIMPLY IS NOT TRUE that arteriosclerosis is part of the normal and natural process of growing old, according to Dr. Theodore G. Klumpp, an American authority on longevity.

Emphasizing that arteriosclerosis is "not the inevitable penalty we pay for living to a ripe old age," Dr. Klumpp says that the disease is actually a metabolic disturbance. Studies show that one-third of those dying at age 80 or more have little hardening of the arteries.

The basic fact to be kept in mind is that the condition does not develop overnight. What an individual happens to be doing at the time of a heart attack has very little, if anything, to do with the heart attack itself. Heart disease is caused by the twin evils of over-eating and lack of physical exercise.

"Contrary to popular opinion, people do not work themselves to death, but rust away and eat themselves into the grave. The proof is in the fact that almost half of the heart attacks occur during sleep, and only two per cent during severe exertion."

Business men are the outstanding victims of the mistaken notion that overwork and physical exercise lead to heart attacks, despite data showing an equal incidence of attacks among all groups, Dr. Klumpp noted.

In addition to eating in moderation, Dr. Klumpp called attention to the benefits of regular exercise and participation in sports. Physical activity is more important for its effect in maintaining a balance in the body's endocrine or glandular pattern than for the amount of calories burned, he said.

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The Role of the Nurse in Society

Sister Mary Cecil, D.M.

The specialization of which our time is so proud has made possible many of our advances. The modern speed of production results because every worker has specialized in his own technique and can put out his product in a minimum of time. Specialization has likewise widened and deepened the field of knowledge with the result that we have resources undreamed of in earlier times at our command. Specialization in every field has developed experts, who can make available to the laity all the wealth of knowledge or the skill in execution that they have acquired. In the professional field, specialists are a necessity today. What would law, education and, above all, medicine do without their specialists? Certainly, specialization has had vast and valuable results.

But like all things human, specialization has its defects. All is not good in this system which divides life up into separate compartments, none of which communicates with any other, nor have all its effects been beneficial to mankind. Specialization has broadened and deepened the field of knowledge but, in almost the same proportion, it has narrowed and foreshortened the mind of man. Each is so intent on, so absorbed in his own branch, that he loses, little by little, all interest in other things. He develops what has been aptly named a "one-track mind."

Every one of us would resent even a hint that ours was such a mind, but professional people are in greater danger, perhaps, of becoming so atrophied. Their fields, being one that ever broadens, becomes more and more fascinating the more deeply it is studied, and can easily claim the whole attention of its devotees.

Take the profession of nursing, for instance. Your work is the care of that most complicated and delicate creation, the human body, the masterpiece of God's handiwork in the sphere of matter. The thousands of years' study of it have revealed only a fraction of its secrets. Every day scientists are discovering new truths about it, stranger and more interesting than those already known. No wonder that it claims the undivided attention of its practitioners! Further, the practice of medicine is carried on, not in a vacuum, but in the medium of persons — patients — who are likewise capable of arousing your interest. The patient, being ill, appeals to your womanly sympathy, and your interest becomes not only professional but personal. Less wonder, then, that you become totally absorbed in your work — that once a nurse, everywhere a nurse!

Such is the natural tendency of a profession that is loved and faithfully practised — it tends to usurp the whole life. But here, let me quote the advice that you have given time and again to your patients — "Forget your work! Relax! Loosen the tension strings that hold you to your professional duty when the hours of duty are ended for the day."

Work is wisely limited to only a certain part of each day. For eight hours you are a nurse with every thought, action and intention centred on your lofty work of bringing healing to suffering humanity. When the eight hours have run their course, your professional work is done and you may, nay, you must leave the sphere of duty for that of pleasure. You doff your uniform, the symbol of your dedication, and put on the clothes that make you indistinguishable from any other woman in the world. Not that the uniform makes the nurse but it is the outward sign by which the nurse is recognized. There remains, however, another sign whereby the inner person may be made known. As the servant of the high priest said to Peter,

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"Thy speech doth betray thee." Ununiformed though she is, the nurse may still be recognized by her conversation, which slips back so easily into the grooves it has followed during all those duty hours.

You may ask, how could it be otherwise? A good nurse's heart must be in her work and it is out of the abundance of the heart that the mouth speaks. Yes, the nurse's heart is with her patients, with suffering humanity, and rightly so. But, may I suggest that during her hours off she transfer her interest to humanity in general — to that portion of it which she meets as simple fellow citizens when she moves out of the professional sphere into the social. She here meets a different class of people, people who have no need of her skilled ministrations. She has changed her dress but not her nature. Her nurse's heart, beating with the same sympathy under her civilian clothes, prompts her to make herself, in the words of the Apostle, "all things to all men." To do so she must make their interests her own. Here the nurse has to cope with one of the queerest streaks in human nature. We mortals are vastly interested in our own sickness, but very little concerned about sickness in general, and still less in anybody else's sickness. Therefore the nurse must make for herself a new range of interests, by means of which she may enter into and influence the lives of others during her time off.

How should she go about doing it? That is a very large question, which it would be difficult to answer fully, but here are a few pointers that may show the way to the answer.

Cultivate a Hobby

Look for one as far removed as possible from your usual sphere of action. That point settled, there arises a question. What hobby shall I choose? Since it is to be *your* hobby, it would be well to take a survey of yourself and your aptitudes to decide what line would suit you best. Are your special gifts physical, intellectual, artistic, social, or domestic? Perhaps you think you have no special gifts at all. If so, you are just like most of the rest of us, but do not let that trouble you. You can still find a suitable hobby. Review your interests, the things you would like to be able to do, the things you have always wanted to do, the career you would have chosen if you hadn't been a nurse, and let one of these show you the way that will lead you to a pleasurable and profitable hobby.

If neither of these methods proves successful, there is still the tried and trusty resource of a book. What can't be found in a book on hobbies is hardly worth finding! Let me give you a sample of what may be found in one book:

> Plastic craft, adventures in whittling, making model cars, airplanes that fly, model railroads, stamp collecting; soap sculpture; book binding, paper decorating and portfolio making; finger painting, paper pulp modelling and crayon craft; square knotting, netting; making dolls, doll houses, and doll furniture; decorating textiles, block printing with linoleum; working with leather, felt or metal; drawing, lettering; indoor gardening; photography; pottery; card tricks, magic; basketry; how to make flies and fishing rods; wood-working and toy making; weaving.

That bewildering list comes from a book of only 300 pages. The problem becomes not what hobby shall I choose, but which ones shall I leave for somebody else. Now that we have settled the question of hobbies, we may go on to the next point.

A New Line of Study

Study! Don't let that word frighten you. Study is naturally interesting. What makes it terrifying is the dread of the examinations that follow it. If you start on a new line of study of your own volition, learning will be the intrinsically intriguing thing that it was in the garden of Eden.

Here again you have a host of things from which to choose. You should take a survey of your aptitudes in order to make a good choice. What studies did you like best when you were at school? You would probably still do well in them now. Perhaps one of them was literature. That would be a fine choice for a nurse whose work brings her

hourly into contact with people, real people, after whom the people of literature are patterned. From the characters of literature and the way they respond to different methods of treatment, the nurse can learn a great deal of practical psychology.

There is this great advantage in making friends of the characters of literature — you can always enjoy their company. There is never any danger of them annoying you as your real-life friends sometimes do. Or perhaps you liked foreign languages; maybe you have always cherished a secret desire to master Norwegian. Does it seem an impossible task to learn a new language in adulthood? It isn't, really. Think of the numbers of people who have come to Canada in the last few years who have acquired English — some of them to an astonishing degree of fluency. We do not consider ourselves less intelligent than they, do we? If they can master our language, why cannot we master theirs? Of course, they have a motive that we lack — perhaps the most compelling of motives, necessity. We could make up in eagerness and determination what we lack in the compulsion of circumstances.

What method do I suggest for learning a foreign language? I shall give you a choice. One way is to associate with people who speak the language you wish to learn. Listen carefully and intelligently to them when they speak. Join in conversation, even at the expense of your pride. In a surprisingly short time you will be able to fumble your way through several sentences. Be prepared to be laughed at, occasionally. As we all know from listening to beginners' attempts at English, some twists of phrase and accent are so funny that even the most kind-hearted cannot restrain a smile. But the sense of accomplishment and the satisfaction that comes with it will be far greater than even that cost.

In the process of acquiring the new language in small enough doses to be digestible, you could use the following method which was devised, I believe, by the U.S. Army in their endeavor to make the men familiar with a foreign tongue in a relatively short time. Learn an easy word of common occurrence, for example, "house." Then add a modifier — "big house." Then put a verb to it — "Look at the big house." Then another modifier, adjective or adverb — "Look at the big red house over there." This method is eminently practical, since it builds an everyday vocabulary gradually and in logical order. There is a third method I might suggest — one to be used as a last resource. Get a dictionary of the language and go through it from A to Z. If you are reduced to such an extremity you will need an heroic degree of determination to persevere, but the more power to you for so doing! I know of one person who learned to speak Hungarian by this means.

If this method of broadening your interests seems to involve more labor than the profit it brings, consider the double benefit that will accrue to you from it. Not only will it open to you another world wherein you may refresh yourself after your professional duty is done, but it will also broaden your professional sphere and increase your professional usefulness. You will be, as it were, two persons instead of one — two nurses instead of one — a Norwegian nurse as well as an English nurse. No need to remind you how difficult it is to nurse a patient whose language you do not understand nor how such a patient's chances of recovery are sometimes jeopardized by this simple inability to be understood, nor how he immediately responds to, perhaps, inferior professional services given by a nurse who can make herself understood.

There is then a new joy you can bring to your patients. A fine old chaplain with a flair for languages used to make it a point to say a few words of greeting in their native tongue to all the patients whose language he could master. What a light filled even the dullest eyes when the familiar sounds were spoken in such unexpected circumstances!

Maybe yours is a scientific bent. You could take up the study of psychology. Here again you have a study

that is most valuable for any nurse. Psychology deals, as you know, with that most fascinating and baffling creature — the human being, which is you, and of even greater interest to each of us — **ME.** Here you may find out what you are and why you are that way. What makes you do the things you do; the influence of heredity and of environment; what motives impel you; the mutual relations of intelligence, will and emotion; the nature and destiny of man. When you have exhausted the field of general psychology there is another world of knowledge waiting to be explored — all the branches of psychology — abnormal, criminal, child, adolescent, feminine, to mention only a few. I would venture to predict that, should you decide to study psychology, you will become so charmed by it that casual acquaintances, judging you by your speech, may take you, not for a nurse, but for a psychologist. The remedy will then be worse than the disease!

For those whose turn of mind is practical, there is a study that will suit them to a T. Take up economics — and learn how wealth is produced, distributed and consumed. Do not let that definition mislead you into thinking that once you have mastered economics you will automatically produce wealth! You may merely know what laws were operating in the production of someone else's wealth. Economics is a very appropriate study in these times when so much contemporary history is connected with economics. Labor and management so often claim the headlines of our papers that one is almost forced to talk of them — a knowledge of economics would enable us to talk much more profitably and intelligently.

Another study of limitless possibilities not only for time, but for eternity, is religion. You may object that religion is a most dangerous topic for discussion. Anyone who brings it up in social conversation is bound to make enemies not friends. Far better to talk about non-denominational nursing. Yes, religion is a controversial subject, because people have such deep feelings on it but it need not be discussed in a controversial way. Like every other branch of knowledge, religion embraces a body of facts about which there need be no bitter controversy. When a discussion centres strictly around facts, there is usually little disagreement; the differences of opinion arise over the interpretation of the facts.

I have said that religion is a limitless study. It is, because it is concerned with God Who is infinite. No other branch of learning can so broaden the mind and enlarge the sympathies. Depth and earnestness of conviction, willingness and ability to discuss religious problems are not a hindrance in social life. To prove my point, let me quote the example of that Man of all men whose whole life was consumed in the service of religion — the Man-God, Jesus Christ. If you read through the — may I call it meagre — sketch of His life left to us in the Gospels, you will find Him often in society. A guest at dinner in the homes of all sorts of persons, rich and poor, high and low, friend and enemy. He spoke openly and pointedly of religion, belief and practice. The company, far from being bored or antagonized came back for more, though many of them disagreed with Him on many points.

Human nature and interests in the first age of Christianity were not noticeably different from what they are now. The sophisticated world of that day was just as materialistic as ours. Ours is no less hungry for religion. Most people agree that we could do with much more real religion today. Why not deepen our own so as to be able to bring more of it into society with us? Does this seem to be much too long a plug for religion on what is supposed to be a professional or social topic? Well, you see, religion is my profession and my profession, like yours, tends to crop up in all my conversation!

The Arts

No doubt there are some of you whose preferences are for the arts in one form or another. What a realm of enchantment you could build up for yourself in this field, whether you con-

centrate on appreciation or execution. Art appreciation may seem a very "long-haired" term, but we all practise it in some form or other by the simple fact of liking some form of art. We can like only what we know, so, if we would broaden our art likings, we have simply to broaden our knowledge. Art products are like people — they usually improve on acquaintance. Give yourself a chance to become acquainted with the master-pieces of any type of art. Have yourself introduced, say, by a friend who knows the way around, so to speak, and you will soon find yourself liking your new contacts. Perhaps you do not have much opportunity of seeing master-pieces, but in our age of rapid production, good copies are readily available. They can give you a feeling for painting that may grow into an absorbing interest.

Radio has brought the works of genius in music into our very living-rooms. We may feel out of place in their company at first, but again, if we could be introduced by a mutual friend, we would soon discover the charm that often lies hidden behind a rather forbidding exterior, and a whole new world would lie open to us into which we could journey at no expense at all in our hours off.

Let me make a further suggestion on the subject of the arts. You need not limit yourself to appreciation only. Try your hand at execution also. Here, so many people are the victims of a mistaken modesty. Because they cannot perform as a virtuoso, they do not perform at all. What an injustice they do both to themselves and their friends! Granted that you would not rank with Paderewski as a pianist, sing as well as Lily Pons, or play the violin like Yehudi Menuhin. Your friends don't expect you to. They would be very glad if you would just do what you can do. They would think it quite sufficient entertainment for a cozy evening at home.

Do not think, either, that your type of art is useless. Every type has its place. If the only thing you can play is the mouth organ, play it anyway. True, the mouth organ is not as soul-stirring an instrument as the pipe organ or the cello, but it is much more practical on many occasions — a weiner roast, for instance.

Music is a most appropriate hobby for a nurse, because as we know from experience, and as has been proven scientifically, music is most soothing to the sick and the weary. If you prefer color to sound, then color, and so express yourself. You will help yourself by giving your emotions a profitable and legitimate outlet. You will develop a new interest that will pave the way for new and broader friendships in your social life. Your friends might be glad to have some of your sketches, too. If you like plastic art, why don't you try modelling? It seems a most popular pastime at present, and would lead you to a host of new friends, in whose company you would become for the time being not a nurse but a modeller.

Friends

Our world is made up not only of *things* — very much more is it made up of *persons*. It is with persons that our next point will deal. Make friends among others than medical people. Your working hours are spent in the world of medicine. Your hours off are officially called recreation — re-creation, a making over of yourself. Your life should lose its medical form and assume some other, both to refresh you and to enable you to return to your professional sphere with added zest — the glad-to-be-home-again feeling that can come only when one has been away. How and where are you to find these non-medical friends? The hobbies that we described may start you on the road to new friends. If you are an ardent stamp collector you are bound to meet others of the kind and among them there will certainly be some to whom you will be attracted. In such company, the conversation will turn, not to medicine, but to stamp collecting.

Another avenue to non-medical friendships would be sport. Do nurses need be reminded that they must have some physical exercise to keep in trim for their exacting work? There is no lack of possible choices in the field of

sport. Here, again, do not let your feeling of inferiority hold you back. You may not skate like Barbara Ann Scott, but that is no reason why you should not skate at all. For you it is simply relaxation and fun, not serious business, as it is for her. Perhaps she nurses for fun! When choosing your sport, it might be well to look longer at those that require more players, to insure meeting a larger number of people. You and your inner circle of nurse friends may easily have a game of tennis or badminton and never move out of your medical environment, whereas if you bowl or curl or play volley ball, you will more than likely meet persons from outside your world. As your body relaxes in the game, so will your mind relax in talking it over afterwards.

Sports bring us naturally to another timely topic, that of clubs. What is there more of than clubs? A speaker at a teachers' convention said, "Our students are clubbed to death. We have clubs for every conceivable purpose."

Whatever hobby you may engage in or whatever study you may pursue, you are sure to find a corresponding club. In the yellow pages of the telephone directory there are names of clubs and organizations — and these, be it noted, are those only that have a telephone! The list, therefore, includes only a small number of the many clubs that the average community will have. That brings me to my final point which is not of my own concoction at all. I copy it from a music teacher's advice to fellow music teachers. On my own, I would never venture to give it, because it is quite out of my competency. It is this — don't marry your own! That can be interpreted for nurses with matrimonial aspirations, don't marry a medical man! If you do you will be inescapably bound to the medical profession "until death do you part."

We of the laity think that it would make for a more equitable distribution of medical knowledge — a great asset in bringing up healthy children — if doctors married stenographers or salesgirls, and nurses married mail-carriers or trolley-drivers. There is, of course, the exception to every rule, so if any of you have already made plans which have thus far been successful, for capturing the attention of the lately arrived handsome and promising young doctor, you can disregard that last bit of advice and go right on with your plans. My best wishes for success!

To put an end to these ramblings let me remind you that of all the professions which a woman may take up, yours is one of the most universally loved and respected. It is so perfectly suited to woman's nature, whose heart is so quick to perceive the hurt, whose hand is so gentle to soothe it.

It is no less suited to woman's supernature, if I may so call the Christian woman living the life of sanctifying grace, for it is the profession of the corporal works of mercy, that compendium of good deeds on which we shall be judged at the last day. "I was sick and in prison and you visited me . . . As long as you did it to the least of these my little ones, you did it to me. Possess the kingdom prepared for you from the foundation of the world." The model you have to follow is none other than Christ himself who went about doing good, who healed broken bodies as well as shattered souls, who likened Himself to a physician, Who promised a reward for a cup of cold water given in His name. It is so often recorded of Him that to the healing touch for the body He added some word of solace and comfort for the soul — a word exactly suited to the character of, and easily understood by, the person to whom it was addressed, spoken not in the professional language of the Eternal Son, speaking to His Eternal Father, but in the homely language of the Son of Man speaking to His brother men of things which were of intimate concern to them that, thus winning their hearts, He might draw those hearts to love His Father. Go then, and do ye in like manner.

The world is full of people who are making good livings but poor lives.

Dependence upon Depressant Chemicals

R. G. Bell, M.D.

Man is a social being and only survived on this earth through group effort. Accordingly, it is normal and healthy for man to be dependent. No human is strong enough to stand alone. Dependence becomes abnormal and unhealthy when people learn to depend on the wrong things and methods — a type of dependence not included in nature's plan for the human organism.

Although it appears normal that people retain a certain dependence upon other people, the type and degree of this dependence normally varies a great deal from infancy to old age. It is just as abnormal for adults to retain the dependent relationships of childhood as it is to develop a dependence on chemicals. Frequently the one leads to the other. Adult dependence must work in two directions, or in other words become interdependence. If we depend on other people then we must also have other people depend upon us.

When one looks for common factors in those who learn to depend upon chemicals, they are at first difficult to find. All types of people appear to become addicts. However, those who become addicted to alcohol or sedatives consistently appear to have at least two things in common. They have reached an age when adult adjustment techniques are required, and secondly, they do not experience a feeling of security in their relationships with others. They are denied the comfort that naturally follows healthy interdependent relationships. Frequently they have had an experience as infants or children which made them distrust other people; made them resentful or frightened when dealing with others.

Social factors may contribute, but are less significant. Many who move to a new city are lost in the crowd. They can live for many years without developing new relationships which would provide a sense of security and belonging. Occupational factors can also contribute to a failure in the development of satisfactory interdependent relationships.

In a well-integrated interdependent group any blow or problem particularly affecting one of the group is automatically shared by others. The people who are unfortunate enough to be cut off from good relationships with others by psychological or social factors must try to absorb life's blows alone. In a very real sense they are over-exposed and are forced to deal by themselves with more problems and troubles than was ever in nature's plan for humans. The adult who cannot depend on other people will undoubtedly be more tense, more frightened, more unhappy than those with satisfactory interdependent relationships. He is the victim of uncomfortable emotional states that are not relieved by his own efforts. Denied the comfort of dependence on other people, he can learn to depend upon chemicals.

There is a group of chemicals, generally known as depressants, that is capable of dulling the awareness of environmental stress. No chemical can reduce the intensity of the problems affecting a particular individual, but many chemicals can change that individual in such a way that he is not aware of these problems. He feels more comfortable because the world has, to a certain degree, lost its ability to hurt him. The depressant chemicals can be roughly subdivided into three groups— anesthetics, sedatives and narcotics. The one most commonly utilized to reduce tension, pain and the awareness of trouble is man's oldest anesthetic — alcohol. The person who learns to depend upon alcohol to reduce tension

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states does so because he has nothing else at his command to deal with these states effectively. By trial and error he discovers that a certain level of alcohol in his body produces unique effects that he welcomes. At last he has discovered a method of adjustment to a painful world that works for him.

"The first half" of addiction is a dependence upon chemicals to produce a certain effect. Finally the body becomes so conditioned to receiving this chemical that it begins to accept its presence as a "must." At this stage to be *without* the chemical will produce tension. An added feeling of physical need for the chemical is acquired and true craving begins. Thus the complete picture of addiction with both a psychological and physical dependence is established. In order to develop a physical craving for alcohol, it is considered that significant changes in body chemistry are brought about by repetitive exposure to large amounts of alcohol. Drinking because of a physical craving is *disease drinking*. The earlier drinking because of a psychological need only, is *symptomatic drinking*. When true craving has been established, disease from the chemical alcohol is considered to have been added to the psychological and social ill-health that initially produced repetitive heavy drinking. In practice, disease drinking follows two courses, chronic daily excessive drinking or periodic bout drinking.

Disease from chronic overexposure to alcohol is better understood if we think of disease from chemicals generally. It is theoretically possible to develop disease or changes in the body from repetitive over-exposure to any chemical. The higher the concentration, the shorter the time required to produce changes. Any "non-poisonous" chemical could be changed into a "poisonous" chemical by increasing the intensity, frequency and duration of exposure. Thus the first variable in disease from chemicals is the exposure factor — intensity, frequency and duration. The second variable, always an unknown, is the individual resistance to a chronic toxic exposure. If 30 men of the same age were to begin to indulge at the same time, in exactly the same pattern of heavy drinking from day to day, they would not all acquire changes in their bodies at the same time. However, we could not predict in advance which one would break down early and which one would be late. Our clinical experience to date with approximately 2,000 patients, indicates that most people will acquire disease from alcohol within 10 years of the beginning of heavy drinking for any combination of reasons. Those who continue to drink without acquiring disease either maintain a subtoxic exposure or toxic drinking is not maintained long enough to produce changes in body chemistry.

When we consider disease or changes in the body, we must think of two types of change. The first would be a temporary reversible change concerning which we might be justified in using the word "cure." The second type involves irreversible permanent changes that cannot be cured but can be controlled if proper treatment is undertaken. It is considered that the change involving true craving for alcohol or other depressants is an irreversible change. In other words, uncontrollable craving will be re-established upon effective, tension reducing, re-exposure to that particular chemical. Thus, in treatment, the person must be taught to deal with old problems in a new way. Having acquired disease from a "medicine," that "medicine" must be discontinued for life.

When a patient discontinues using alcohol in times of stress, he at first has no new way to deal with his old problems. Accordingly, he must be trained. We believe that Sir William James was right when he said "Seldom if ever does a person live to the limit of his abilities. He possesses power that he always fails to use." This applies to addicts just as to anyone else. The function of a clinic is to make patients aware of these abilities and to direct the harnessing of these abilities in a new way.

The clinic should continue to recognize the need of each patient for a new feeling of security. The patient himself had shifted from a dependence upon

people to dependence on chemicals. In order to live happily without chemicals, he must now shift back from a dependence upon chemicals to a new dependence upon people. He must, in a new way, participate in interdependent relationships. This fundamental principle of treatment was first identified and then proven by Alcoholics Anonymous, and must always be kept in mind by any clinic undertaking the rehabilitation of the alcohol or sedative addict. It should also be pointed out that to shift from dependence upon one depressant such as alcohol to other depressants such as barbiturates, carbromal, bromides, etc., is simply stepping from the "frying pan into the fire." There is no place for the administration of sedatives in the rehabilitation of the alcohol addict.

In the January, 1953, issue of *The Canadian Medical Association Journal,* an article was published entitled "Clinical Orientation to Alcoholism." In this article pre-disease and disease drinking was described in seven stages. It is suggested that the nurse interested in pursuing this study further, refer to this article. All seven phases will be of particular interest to the public health or industrial nurse. A knowledge of the first three phases would be necessary in order to practise prevention. Nurses working in hospitals or on private duty will encounter alcoholics in phases 5, 6 and 7, and improved understanding of disease drinking should make it possible to maintain the proper attitude in nursing care.

The industrial or public health nurse is frequently called upon to deal with the many problems that follow alcohol addiction. It is imperative that she be able to discuss these problems intelligently with families. It is important that she realize that the new clinics are becoming more and more effective in helping alcohol or sedative addicts. Finally it is very important that she be able to think of treatment as a shift in dependence. If she keeps this in mind she will be in a position to utilize health and social agencies in the community according to the particular needs of the patient and his family.

Interpreting Nursing to High School Girls

CHRISTIAN SMITH, director of health education for the Saskatchewan public health department, urged some 300 women students of Regina's high schools to "have a sense of value and not sell the best things of life." The students were introduced to nursing as a career at the special program planned jointly by the Regina Grey Nun's school of nursing and the Saskatchewan department of public health. The theme was "The Nurse — Pioneer of Health."

The director contended nursing was a "great profession" and it provided the best opportunities for service. Students, when thinking of the three-year training period, often thought of other occupations at which they could be earning money much more quickly. "I have learned that money is the least important thing of all," said Mr. Smith.

"You are the future women of Canada. You will mould the coming generation of children; you won't stay with nursing indefinitely! The greatest need is for you to grow up and be mature. What is more important is that the maturity and discipline you will receive from a nurse's training will help you as a wife and as a mother."

The World Health Organization, Mr. Smith said, was comprised of 80 nations. He explained how the organization worked and the experiences of doctors and nurses. Public health nurses went into other lands and taught those people how to live happier, healthier lives. Those nurses do basically the same work as the public health nurses in this country, finding satisfaction and happiness as a reward.

Miss C. Kenney, science instructor at the nursing school welcomed the students. Sister Levasseur led the symposium outlining the nurse's training course presented by four nursing students and included in her address the qualifications of a nurse. The future nurse must be a pleasant person with good moral conduct. She must have con-

fidence, be sympathetic and have self control.

Miss Shirley Lynch explained the studies of the *junior year* and described the student's residential life. At the end of six weeks the students began ward duty and then eagerly awaited the capping ceremony when "we wear white caps and are proud of them."

Miss Edna Miller gave a brief summary of the intermediate year's work. In the second year of nursing, ward experience predominated. She described the pleasure of actually working with patients.

Miss Audrey Minty described the *senior year* when students took a greater share of responsibility. The third year was spent in perfecting nursing skills and in experience in more specialized fields, including affiliation in other hospitals and organizations.

Miss Joan Cousins, a 1954 graduate, said the final test for students came in the preparation for the registered nurses' certificate. She described the three big days prior to the awaited moment — the graduation exercises. "The opportunity for nursing is ever increasing. Nursing offers many opportunities as you finish your high school education."

A display of dolls graphically illustrating nursing history was on view for the students. Guests were conducted on a tour of the hospital and the nurses' residence. Refreshments were served informally.

It is now generally agreed that both the initial and recurrent attacks of rheumatic fever are usually precipitated by infections with beta hemolytic streptococci. Therefore, the prevention of rheumatic fever and rheumatic heart disease depends upon the control of streptococcal illnesses. This can be successfully accomplished by early and adequate treatment of "strep" infections in all individuals through the use of antibiotics, and prevention of "strep" infections in rheumatic subjects by means of antibiotics or sulfa drugs.

"Strep" infections are usually of the nose, throat or other respiratory passages. At least three per cent of untreated "strep" infections are followed by rheumatic fever. Those who have had an attack are particularly susceptible to a recurrence if they develop a "strep" infection, with greatly increased liability to serious heart damage.

—*American Heart Association*

Nursing Profiles

Hilda M. Bartsch has assumed the office of executive secretary and registrar with the New Brunswick Association of Registered Nurses with her headquarters in Fredericton, N.B. She brings to her new duties a very thorough understanding of the many facets of provincial association activity for she served during the 1948-50 biennium as president and until recently was a member of the Board as past president of the association.

New Brunswick is Miss Bartsch's native province. After receiving her preliminary education in Saint John, she went to The Montreal General Hospital for her professional training. Upon graduating she joined the staff of what is now called the Reddy Memorial Hospital, first as a head nurse, then, five years later, becoming assistant superintendent of nurses. Following three years as a clinical supervisor at the Vancouver General Hospital, Miss Bartsch enrolled at the McGill School for Graduate Nurses. Her next appointment was as instructor at the Alexandra Hospital. In 1943 she returned to New Brunswick as superintendent of the Victoria Hospital, Fredericton. She went into a specialized field for a couple of years as director of nursing at the Moncton Tuberculosis Hospital. It was during her five years as director of nursing at Carleton County Hospital, St. Stephen, that the new buildings were planned and constructed. All of this background knowledge will prove of immense value, from a consultive point of view, as Miss Bartsch develops her new program in the months to come.

Harvey Studio, St. Stephen

HILDA M. BARTSCH

Mary Kathleen Ruane has become the director of nursing services of the new University Hospital, Saskatoon, Sask. Of Irish descent, Miss Ruane was educated in Winnipeg, graduating from the Misericordia General Hospital there. She has had broad experience in many phases of hospital work. For the past nine years she has been superintendent of nurses at the Children's Hospital, Winnipeg. She has had many years of experience in association affairs, being until recently first vice-president of the Manitoba Association of Registered Nurses.

M. KATHLEEN RUANE

Yvette Schroeder of Luxembourg has accepted a year's appointment with the Florence Nightingale International Foundation of the I.C.N., to carry on research with the Foundation. Miss Schroeder will be well known to many Canadian nurses through their contacts with her while a student at Teachers College, Columbia University. She received her M.A. there in 1952, specializing in research methods.

Jessie Margaret Wilson is trying her hand at a new phase of hospital activity. After serving for ten years as the administrator of the General Hospital, Brantford, Ont.,

JESSIE M. WILSON

from which she graduated, Miss Wilson has taken over the duties as director of nursing at the Greater Niagara General Hospital. A graduate of the course in administration and teaching given by the University of Toronto School of Nursing, she has also been superintendent of the Memorial Hospital in St. Thomas, Ont. Miss Wilson brings to her new work a fund of knowledge and experience that will ensure her success in this responsible position.

Alma F. Law, who has been the capable executive secretary and registrar of the New Brunswick Association or Registered Nurses since the official headquarters was established 13 years ago, has retired. Miss Law has witnessed and participated in the considerable expansion of the programs of the association during the busy and trying years that followed her appointment in 1941. Always exceedingly modest regarding her own contribution, she also included among her duties, until three years ago, the added responsibilities of official visitor and consultant to the schools of nursing in the province. During World War II she took a large part of the responsibility for administering the federal grants for nursing education. A graduate of Saint John General Hospital, Miss Law had wide experience as a supervisor and director of nursing before the Association's call beckoned her. Now she plans to enjoy her home at Oak Point, N.B.

Alice Beyer Hunter, who has been associated with the General Hospital in Port Arthur, Ont. since 1938, has returned to her beloved Ireland where she plans to "keep house, learn to cook and look after the lovely big garden." A graduate of Toronto General Hospital, Miss Hunter served as a head nurse on a surgical ward there for 10 years prior to becoming assistant superintendent of the hospital in Port Arthur. She was chosen as matron of the Canadian Orthopedic Unit, organized in 1941 by the Canadian Red Cross Society at the request of the Ministry of Health for Scotland. When she returned to Canada in 1945, Miss Hunter was named superintendent of the Port Arthur hospital, relinquishing some of the arduous responsibilities to become assistant administrator in 1951. Prior to her departure for County Tyrone, Miss Hunter was guest of honor at many affairs and was the recipient of many lovely gifts.

Catherine Maddin, a veteran supervisor of public health nursing in Winnipeg for nearly four decades, retired last spring. A graduate of St. Boniface Hospital, Miss Maddin was one of four nurses employed by the City of Winnipeg when she joined the staff in 1916. Two years of service with the C.A.M.C. did not divert her interest in infant welfare work. She rejoined the health department on her discharge from the army. She opened the first baby clinic following a nine months' post-graduate course in New York in 1925. Miss Maddin looks back on her long years of activity in public health nursing with deep satisfaction.

Grace H. Orr has retired after serving in various capacities at the Saskatchewan Hospital in North Battleford, Sask. for the past 25 years. A graduate of Victoria Hospital, Prince Albert, Sask., Miss Orr was forced by ill health to relinquish the post of superintendent of nurses four years ago. Since that time she has served as matron housekeeper. She has returned to Prince Albert to reside.

To avoid criticism do nothing, say nothing, be nothing.

In Memoriam

Martha Batson, who graduated in 1921 from The Montreal General Hospital died there on July 30, 1954, at the age of 66. Miss Batson had been in poor health for several years. Appointed educational director at M.G.H. in 1928, she had a busy and successful career in her chosen branch of nursing prior to her retirement.

* * *

Effie J. (Smith) Cadenhead, a graduate of Toronto Western Hospital, died at Oshawa, Ont., on July 9, 1954, in her 79th year. Mrs. Cadenhead had been in failing health for several months. Prior to her marriage in 1939, she was assistant superintendent of nurses at the Oshawa General Hospital for some time.

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Eleanor Kathleen Cowan, who graduated in 1926 from St. Michael's Hospital, Toronto, died suddenly while engaged in active duty at her Alma Mater on April 29, 1954.

* * *

Lillian H. (Beatty) Davidson, who graduated from the Toronto General Hospital in 1910, died on April 6, 1954. Mrs. Davidson was active in many phases of community life. For several years she was a member of the Toronto Board of Education.

* * *

Christine Margaret (Baillie) Ferguson, who graduated from Victoria General Hospital, Halifax, in 1923 died at her home in Tatamagouche, N.S., on June 29, 1954, following a brief illness. She was 57 years of age.

* * *

Sarah Annie Kinder, a graduate of New York Polyclinic, died on July 20, 1954, at London, Ont., where she had resided since her retirement in 1935. Miss Kinder made an outstanding contribution to the early development of the Hospital for Sick Children, Toronto. Endowed with great teaching ability, she was appointed the first full-time instructor there in 1906. She was given the appointment of assistant to the superintendent of nurses in 1913. In 1921 she accepted the superintendency of the Children's Hospital, Winnipeg. She served in a similar position at Children's Memorial Hospital, Montreal, for the last ten years of her busy professional life.

* * *

Edith (Gaskell) Ludwig, who graduated from Toronto General Hospital in 1903, died on June 12, 1954.

* * *

Frances M. (Stewart) McCartney, who graduated from McKellar Hospital, Fort William, Ont., in 1915 died on June 25, 1954, at the age of 62.

* * *

Anne (Connelly) Manson, who graduated from the Greater Niagara General Hospital in 1932, died suddenly in Montreal on July 13, 1954. Mrs. Manson was in private nursing for several years. For a short period she was night supervisor at G.N.G.H. Recently she had been employed on the graduate staff of the Allan Memorial Institute, Montreal.

* * *

Beverley E. Smith, who was completing her second year as a student at City Hospital, Saskatoon, Sask., was instantly killed in a road accident on July 11, 1954. She was 20 years of age.

* * *

Muriel Stewart, who graduated in 1915 from the Royal Victoria Hospital, Montreal, died there on July 26, 1954. She had been in poor health for some time. Miss Smith served overseas during World War I. Most of her professional life since was spent in private nursing.

* * *

Sister Felicitas Sullivan, who graduated in 1915 from St. Michael's Hospital, Toronto, died recently. Sister Felicitas was the first sister in charge of the x-ray department at St. Michael's. In 1923 she organized the History Room. Later she went to St. Joseph's Hospital, Comox, B.C., supervising the laboratory and x-ray departments.

Never hold any one by the button, or the hand, in order to be heard out, for if people are unwilling to hear you, you had better hold your tongue than them.

— CHESTERFIELD

Public Health Nursing

The Role of the Nursing Assistant

in the

Victorian Order of Nurses, Toronto Branch

MAY L. PALK

FREQUENTLY, THE COMMENT is heard that patients with long-term illnesses require nursing care of the highest quality. Just as frequently, the opinion is voiced that the special skills and knowledge of a public health nurse are being dissipated if the preponderance of her service is devoted to patients with chronic illnesses. Is there a conflict between these points of view? Is it possible for a visiting nurse organization to provide the high quality of nursing care, so necessary to the chronically ill, and at the same time use the abilities of public health nurses most productively? It was to test the validity of this hypothesis that an experiment was conducted in the use of Certified Nursing Assistants in the Victorian Order of Nurses, Toronto Branch.

During the past decade, visiting nurse organizations have witnessed a marked increase in the requests for nursing care to patients with long-term illnesses. Concomitant with this unprecedented increase has been an expansion of all public health services throughout the country. This has resulted in a greater demand for public health nurses generally, but no corresponding increase in qualified staff available for employment with visiting nurse organizations is evident. By 1947 it had become quite apparent, in fact imperative, that if the services of public health nurses were to be utilized to the best advantage in our Branch, methods must be explored through which a non-professional nurse could assist in the care of patients who require service over a period of weeks, or possibly months.

Miss Palk is educational director of the Toronto Branch of the Victorian Order of Nurses.

AN EXPERIMENT BEGINS

In July of that year our experiment was started. Two certified nursing assistants, graduates of the 9-month course directed by the Ontario Department of Health, were employed to work in a team-relationship with public health nurses. Following the sanction of the proper Victorian Order authorities, the initial step was to plan with staff for the introduction of this type of nursing personnel. In this stage of our planning we were particularly fortunate in being able to observe the use of practical nurses in one of the large visiting nurse agencies in the United States, and there learned something of their orientation to the district as well as the type of patient-load that is carried successfully by non-professional nurses.

In the two district offices to which the nursing assistants were to be assigned, the patient-load was analyzed carefully. Only those chronically ill patients whose nursing needs could be met adequately in a team-relationship were chosen and, in the main, these patients were in the older age bracket. Following the selection of patients the question arose as to the interpretation of this worker to physicians, patients, and to the general public. Another factor to be considered was the drawing up of personnel policies that would be appropriate for nursing assistants.

The unexpected smoothness with which our experiment progressed had its explanation, no doubt, in the conscientious and enthusiastic efforts of all who shared in the introduction of this newest member of staff. Physicians

gave their unreserved support, patients entered into the plan with something of the expectation of a child who awaits the coming of a visitor, and staff members accepted their responsibilities for interpretation with a most creditable meticulousness. While supervisors interpreted this new venture to physicians and obtained permission to have a certified nursing assistant care for selected patients, it was left to the district nurse to introduce this non-professional worker to the homes in the community. Doubtless the skill of the public health nurses in creating a positive attitude toward this plan for team work in the home was in no small way responsible for the success of the project. If, however, there was one factor that might be said to have contributed more than any other, it was the quality of nursing care given by the nursing assistants as well as the general acceptance of these new members of staff.

Team Work in Home Care

During the experiment, and in subsequent years, our philosophy has been that the patient in whose care the nursing assistant will share, should be selected most carefully and that, at no time, is the nursing assistant completely responsible for meeting the total nursing needs of the patient. This responsibility remains with the district nurse. Based on this philosophy, certain guides for the selection of patients and the frequency of supervision and care by the district nurse have been outlined. In the beginning of the experiment only elderly patients, suffering from long-term illnesses, were selected and the district nurse adhered closely to the policy of making every fifth visit. During the past year, these practices, at the suggestion of staff, have been somewhat liberalized. However, our philosophy remains unchanged.

Starting the day's visits.

The criterion for the selection of patients is as follows: those patients whose nursing needs may be met adequately by the nursing assistant under the guidance of the district nurse and where the health needs of the patient and family have been met, or may be met in the regular visits of the district nurse. The majority of the patients in whose care nursing assistants share are in the chronically ill group, but in certain situations they do make selected visits to convalescent patients. In each instance the district nurse in consultation with the district supervisor makes the decision. Nursing assistants do not admit patients, discharge patients, neither do they decide on the number of visits to be given.

Just here a question may arise in the mind of the reader — do nursing assistants administer insulin? Is professional nurse time being salvaged from the daily visits made to patients who cannot be taught self-administration of insulin, and where there is no family member to assume responsibility? Again, on an experimental basis, experienced nursing assistants on the staff of the Toronto Branch have been prepared to administer insulin in certain well controlled situations; namely, to patients where no other plan can be made, the dosage of insulin remains constant, a daily urine test is not indicated, and the patient is receiving only one type of insulin. This treatment has been added recently to the duties performed by our more experienced nursing assistants and is given only to carefully selected patients. On that basis it does offer another possibility of saving professional nurse time.

With respect to the frequency of the supervisory visits of the district nurse,

the plan in effect at present takes into consideration the needs of the patients and the experience of the nursing assistant. In some situations the district nurse may make alternate visits with the nursing assistant, as occurs when a treatment, which the non-professional nurse is not trained to administer, is required on every other visit. While the nursing assistant feels free to request the district nurse to visit at any time if she is concerned about a patient, a maximum period which may elapse between the visits of a professional nurse was decided upon in consultation with staff. If a daily visit is made to a patient for the purpose of administering insulin, not more than four days may elapse between the visits of the district nurse. For other patients receiving daily nursing care, the district nurse visits once each week; if a patient is receiving two or three visits a week the district nurse visits every third week; if only one visit a week is needed by the patient, the district nurse visits every month. This rather flexible plan makes it possible for the district nurse to supervise the care given to each of her patients by the nursing assistant, whereas every fifth visit was not always possible for the nurse or necessary for the welfare of the patient and family.

Since it is recognized that professional nursing guidance is essential if the nursing assistant is to make her greatest contribution to the nursing team, considerable thought is being given to the development of suitable tools that will assist the district nurse in this important role. At the present time we are experimenting with a card which is kept in the file of the district nurse, showing the name and address of the patient, the plan for nursing care and a narrative summary of the suggestions discussed with the nursing assistant following the regular visits of the district nurse.

Recording and Reporting

The patient's service record is transferred to the file of the nursing assistant if she carries the majority of the visits to a patient; otherwise it remains in the file of the district nurse.

Office work is important too.

The nursing assistant records her visits in green ink whereas those made by the district nurse are recorded in black. Nursing assistants do not contact physicians for orders and only in exceptional circumstances do they report the condition of the patient to him, but they are encouraged to confer regularly with the district nurse and to report promptly anything unusual or urgent about the patient's condition.

Staff Development

Nursing assistants who join the staff of the Toronto Branch take part in an orientation which is designed to prepare them for their particular role in a visiting nurse service. Through conferences and demonstrations in the classroom, through observation, participation and supervision in the district, the nursing assistant learns to adapt her skills to the home care of the patient. Following orientation, the nursing assistant is included in the regular staff education conferences in her district office if the subject to be discussed is applicable to her work. If not, a separate program is arranged. For example: in studying the care of patients with long-term illnesses or the application of the principles of posture and body mechanics to nursing, the nursing assistant is included, whereas in a discussion relating to maternal and infant hygiene, she is exempted. A planned program of individual conferences and field supervision is carried out by the district office supervisor and affords another means of staff development for the nursing assistant.

Personnel Policies

Many of the personnel policies for nursing staff, namely: sick leave, vacation, hours of work, physical examination, pension plan, Workmen's Compensation, and uniform allowances, were found to be applicable to the nursing assistant. The Toronto Branch chose a dark green uniform for the certified nursing assistant which is identical in style with the familiar blue worn by Victorian Order nurses. Nursing assistants wear white buttons and collar, their own school pin, a black hat and a coat of oxford gray. The nursing assistant does not take holiday, Sunday or night duty, due to the character of the work at these times.

An Experiment Concludes

Beginning the experiment with two certified nursing assistants we have gradually expanded to nine. The decision to increase the number has been based on the fact that many patients required the care which a nursing assistant is capable of giving in a team-relationship with a public health nurse. The favorable and satisfying service of these new members of staff has also been an encouraging factor in the employment of more nursing assistants. At the present time we are not prepared to state what is a desirable ratio between public health nurses and nursing assistants, except to comment that in a nursing staff of approximately 100, nine are nursing assistants.

As one reflects on the beginnings of an experiment which was undertaken with a degree of apprehension and caution, yet prompted by a strong conviction of its validity and soundness, one is tempted to remark: "Why all the concern?" It is explained, no doubt, by the fact that the untried, while challenging, is nonetheless unknown.

Although it is difficult to appraise all the facts in this experiment, it would appear that the patients in whose care a nursing assistant has shared have received a high quality of nursing service. Complaints have been negligible whereas appreciation has been frequently expressed. With respect to a more extensive and prolific use of the abilities of public health nurses, one need only refer to the number of visits made daily by nine nursing assistants to patients with long-term illnesses. If non-professional nurses were not employed in the Toronto Branch, all of these visits would have been made by professional staff. Although the public health nurse is relieved of the frequent visiting required by so many of these patients, she still retains the responsibility for giving the nursing care at regular intervals; for planning and supervising the nursing care given by the nursing assistant; for meeting the needs of the patient and family for guidance in matters of health; and for interpreting, when indicated, the available resources to assist them in working through their social or economic difficulties. It should be logical to conclude, therefore, that with the employment of nursing assistants the sphere of usefulness of public health nurses in a visiting nursing organization has expanded to greater proportions than ever before.

In concluding its experiment the Toronto Branch of the Victorian Order of Nurses feels that the use of the Certified Nursing Assistant has been amply demonstrated and now considers this worker an essential member of its nursing team.

Your greatness is measured by your kindness; your education and intellect by your modesty; your ignorance is betrayed by your suspicions and prejudices; your real caliber is measured by the consideration and tolerance you have for others.

— Wm. J. H. Boetcker.

Institutional Nursing

Central Supply Service

ALMA DOWNING

THE POSITION THAT the Central Supply Department holds in modern hospitals is becoming increasingly important. The experience gained in this service is an essential part of the student nurses' course. The type of work carried on by the Central Supply staff varies. However, the main purpose of this department is central sterilization, that is, all equipment used on the wards is brought to one place, cleaned, wrapped and re-sterilized, thus freeing the nurses on the wards of these duties and leaving them more time to care for their patients.

When our Central Supply Department was first organized we were responsible only for the sterilization of small trays, needles, syringes and such equipment as would be used routinely every day. As time passed, the scope of our work expanded to include the sterilization and distribution of all special or emergency trays as well. Unsterile equipment, such as oxygen tents, steam inhalators and the like are also requisitioned from this department. Penicillin, oxygen and solutions for intravenous use are obtained here.

Recently we have tried various experiments in an attempt to increase the value of our service and thus indirectly improve the quality of our nursing service throughout the hospital. The idea of centralizing certain nursing treatments is relatively new to us. We organized a system whereby all surgical dressings on the wards would be changed by the staff of the Central Supply Department. There were two schools of thought regarding this plan — those in favor felt that student nurses would get more supervision in this important nursing procedure, and that a standard procedure would be established and carried out throughout the entire hospital by graduate nurses and students alike. Those who were opposed to the plan felt that the nurse on the ward would not have complete knowledge of her patient because she would not be changing the dressings and thus would not know the condition of the incision. After discussion, the medical attending staff approved the plan and the new system was introduced on only one ward as an experiment.

As we expected, our problems were many and varied but with further study and experimentation most were solved satisfactorily. At the present time, the central dressing system is in operation throughout the entire hospital and a fairly smooth-running procedure has been developed. Routine dressings are changed every four hours or oftener if required. The head nurse on each ward lists all patients with surgical dressings and the type of dressing to be done. The central supply nurse refers to this list when she arrives on the ward. The condition of the incision, type and amount of discharge and other pertinent information are charted by the central supply nurse and signed for future reference. If a surgeon wishes to change a dressing, the Central Supply Service is notified, and a nurse is sent to assist him.

The Central Supply Department is closely connected with the teaching department, administration office and, in fact, every branch of service in the hospital. Its importance can only be estimated in its value to student nurses. The Central Supply Service supervisor must never forget that she is in charge of a department that is very closely connected with teaching and must be fully conscious of her responsibility in this respect.

Miss Downing is supervisor, Central Supply Department, Victoria Public Hospital, Fredericton, N.B.

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Her name is Mercy

ALL THAT SHE GIVES can never be measured in money . . . her gifts are hard to define . . . she is an angel of mercy labouring unstintingly to bring hope, health and happiness to her fellow citizens.

Our Canadian Nurse in hospitals, home and industry, is dedicated to an ideal of competent service towards sickness and those in deep distress, and she brings to every bedside, not only her professional skill but—best of all, the warmth of human sympathy.

Affectionate, efficient, unassuming . . . no defined hour of duty shall stay her helping hand . . . no call shall go unanswered. She is ready to work for our welfare in peace or in time of National Emergency.

Her unselfish dedication to the continuing needs of others has earned for the Canadian Nurse a nation's lasting gratitude.

• • •

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Industrial Nursing

The Value of the Industrial Nurse

BLANCHE BISHOP

IF WE THINK of the occupational health nurse as another member of the public health team, it simplifies the task of assessing her work in terms of its value to the worker, the home, and the community. All nurses, whether they work in hospitals, institutions, health units, the home, schools, or in factories, have at least one objective in common — the promotion and preservation of the physical, mental and social health of all those with whom they come in contact. I will attempt to interpret this objective in relation to industrial medical services and outline the potential contribution an industrial nurse can make to the total community health picture.

The public health objectives of an industrial medical service may be defined as:

1. Protection and promotion of the health, safety and efficiency of those persons gainfully employed. (preventive Aspect.)
2. Restoration to health and normal functioning of all ill or disabled workers. (curative Aspect.)

In an efficient industrial health service these objectives are accomplished by the following means:

1. Pre-placement medical examinations.
2. Periodic medical examinations.
3. Correction of remediable defects.
4. Supervision of conditions of work.
5. First aid and emergency care.
6. Opportunity for health consultation.
7. Adequate record system.
8. Health education.

The foundation of any industrial health program is the physical examination. The pre-placement examination can be of real value to employees and employer, both from the point of view of placing a man in the job for which he is best suited and also to learn of any physical defects that may prevent him attaining optimum physical health.

Periodic physical examinations are equally important, particularly for the over-40 age group. Each company determines its own policy but the ideal is a health examination every year, or at least every two years. The over-40 group is subject to the so-called degenerative diseases — hypertension, gastric conditions, overweight, etc., that can cause permanent damage if allowed to progress. Our firm has a special policy for its over-40 executives — a complete medical examination every year and an EKG every two years. Because the executive is a valued member of the staff who could not be readily replaced, it is sound economy to keep him in top physical condition. Most people are amenable to suggestion. If they are told the reason why they should adopt a certain course to improve their health (for example, weight reduction) they usually will cooperate. A written record of the year to year physical findings is often the only argument needed.

The follow-up and correction of remediable defects is the natural aftermath of the physician's findings at the physical examination. Merely recording the defect and filing the form destroys most of the value of the medical examination. Such things as decayed teeth, impaired vision, overweight, diseased tonsils, anemia, have a definite relationship to health and must be corrected if the employee is to attain maximum physical health. He must be encouraged to want to correct his defects by developing an understanding of the effects of neglect.

Almost every industry has some type of occupational hazard connected

Miss Bishop is with Weston Bakeries in Toronto.

with it and it is part of the medical team's job to learn the facts about the hazard and the steps that can be taken to overcome it. Dust, fumes, toxic materials — all may be hazardous. The doctor and nurse should make regular inspections of the working environment to become familiar with the various operations and to learn which of the materials may be hazardous. These may be replaced by other harmless substances. The doctor and nurse must be alert to signs and symptoms that might indicate a new hazard. Several employees from the same department reporting with similar symptoms, might be indicative of toxic conditions that require immediate attention.

Very often when he reports for treatment of a minor injury, the employee has his first contact with the nurse. His first impression is generally based on the way she cares for his injury so it is essential that she secure the employee's trust and confidence, reassuring him by her efficient emergency care. The industrial nurse must exercise good judgment and make quick decisions that are the right ones. It is the nurse's responsibility to see that provision is made for employees to receive adequate first aid when the doctor and nurse are off duty. St. John's Ambulance Association teaches First Aid in most centres and employees should be encouraged to enroll in a training course that will enable them to handle minor emergencies.

Both the doctor and nurse should seek to establish relationships within the plant that will develop a good rapport with employees. Workmen should feel free to consult the medical team, assured of a sympathetic, confidential and understanding audience. It has been estimated that half of the illnesses reported to the industrial doctor are of functional origin. Often the employee requires only to be reassured that he is not suffering from an organic condition. He may want to discuss some worry or domestic problem that is causing his physical symptoms. He does not particularly want advice — he wants to talk about his problem and unburden his feelings. Often this mental catharsis is all that is required. He returns to his job feeling better. If his social problem demands professional help, the industrial nurse, from her knowledge of community resources, explains the type of assistance available and helps him plan to seek it. Similarly, if there is some physical basis for his complaints, he is referred to his family doctor for investigation and treatment.

As in every branch of public health work, an adequate record system is a *must*. Statistics help the industrial nurse evaluate her past performance and plan for her future activity. These records must be kept confidential and be available to no one but the doctor and nurse. Each industry must decide the type of records best suited to its individual needs. The nurse is responsible for maintaining these records.

Health education is a very broad and well known field to public health nurses. It may be of interest to consider some of the methods used in industry. As well as such accepted devices as posters, pamphlets, payroll insertions, we believe that individual instruction is most effective. Opportunities for this arise every day. When an employee reports to the medical centre for emergency care or an aspirin, the visit can be turned into an educational experience by inquiries about his decayed teeth or what his family doctor thought he should do about his diseased tonsils, and so forth. The employee should always receive an explanation of the possible consequences if he fails to correct these things, and be allowed to make his own plan after that. Nutrition is one field in which the industrial nurse can achieve results fairly quickly. As part of our pre-employment examination employees are required to complete a three-day diet survey sheet. This forms the basis of our nutrition teaching, and after comparison with Canada's Food Rules, recommendations are made. Overweight is a health hazard that we are particularly concerned about and our recommendations to improve the diet always take into consideration whether or not the employee needs to lose weight.

Another aspect of our health educa-

tion program focuses on improved mental health. The industrial nurse is in a strategic position to recognize the signs of impaired mental health — the malingerer, the absentee, the introvert, the man with a chip on his shoulder. All these require some help and guidance. This is one situation where the good relationship between the medical team and the foreman pays dividends. Often he is the first to notice an employee's early deviation from normal. Every individual must feel important in some sphere. Formerly workers obtained this sense of importance from their jobs — they were craftsmen and they were known to their employer as such. Today's mass production and streamlined methods provide very few opportunities for the worker to feel any sense of achievement in his job. This leads to a sense of frustration unless he can secure this feeling through some other channel. Hobbies and leisure time activities are the answer for most people. The industrial nurse should know what facilities her community offers in the form of recreation, education, hobbies, and crafts thus encouraging employees to seek this outlet. Older workers often need help. Many of them reach retirement age without any plan for their later years. Our company issues a booklet to every worker before he is due to retire.

Summing up the thoughts on mental health, I shall list the ten rules suggested by Professor Bernhardt, University of Toronto.

1. Live in the present. Don't regret the past and don't worry about the future. Enjoy what you are doing.
2. Live easily. Work hard but live easily. Develop the ability to manage your emotions. Avoid emotional extremes.
3. Develop a sense of perspective. Sort out what is most important in life and don't worry about trivialities.
4. Have a goal or set of ideals to give meaning to what you are doing.
5. Develop a wide range of interest in life. All too often, life is a place where

> You dig in the ditch
> to get money enough
> to buy food enough
> to get strength enough
> to dig in the ditch.

6. Develop an experimental attitude towards difficulties.
7. Make prompt decisions.
8. Accept the consequences of these decisions without rationalizing.
9. Develop self-confidence.
10. Develop a sense of humor. Learn to laugh at yourself.

What is the industrial nurse's value to the worker, the home and the community? The answer is obvious. She is dealing with the breadwinner, the one member of the family whom the average public health nurse rarely sees. He is accessible to the nurse at the plant often coming to her for information and guidance. This is the best possible teaching or learning situation — the employee is motivated to seek help. Often he is a parent or a future parent — surely a fertile field for health education. In many industries, a large proportion of employees are women, many of whom are mothers. What they learn about health will be reflected in an improved standard in both the home and the community.

The opportunities for cooperation between the industrial nurse and all other members of the community health and welfare team are tremendous. There should be a closer link than exists at present in such matters as follow-up of former tuberculosis patients who could be employed in industry. The nurse could assist in their supervision if she has demonstrated her ability and interest. The possibilities are great — there remains only the problem of convincing others of the industrial nurse's desire to function as part of the community program.

In conclusion, may I say that any nurse who enters the industrial health field will find her job limited only by her enthusiasm. She will have the personal satisfaction of helping the employees towards improved physical, mental and social health, thus indirectly benefiting the home and the community. She will find her job of dealing with individuals one of the most interesting in the world. She can do a good public health and public relations job and enjoy herself in the process.

Aux Infirmières Canadiennes-Françaises

La Surveillance Post-Sanatoriale

ROLANDE COTE

A L'INFIRMIERE VISITEUSE incombe la tâche de préparer la famille à coopérer à la réhabilitation de son malade. Depuis bien longtemps déjà, elle s'y emploie, mais la mémoire est une faculté qui oublie, dit-on . . . aussi juge-t-elle opportun de faire une mise au point alors que l'on parle de congé médical.

Cette famille si heureuse du retour de cet être cher, est-elle suffisamment préparée pour le recevoir? Est-elle vraiment convaincue que cet ancien bacillaire n'est plus contagieux et ne doit plus être considéré comme tel? Cette famille a-t-elle tout à fait bien compris que sortir du Sanatorium avec congé médical ne veut pas dire être prêt à retourner d'emblée au travail? Accepte-t-elle les sacrifices que lui imposera la lente et progressive réadaptation du patient: diminution de revenu, voire même, changement de profession? Agira-t-elle de façon à obtenir que le patient se soigne jusqu'au bout?

Au point de vue hygiène, saura-t-elle modifier ses habitudes, si besoin, de façon à être un exemple ainsi qu'un encouragement pour le patient? Dans son désir de bien faire, la famille n'exagérera-t-elle pas jusqu'au point de choyer le patient à outrance et même de se substituer à lui, de lui épargner tout effort? Conduite si néfaste et dont tant d'anciens malades ont à subir les funestes conséquences.

Passées les premières joies du retour, que viennent les heurts causés par la difficile adaptation du malade à son nouveau genre de vie, cette famille est-elle suffisamment avertie pour y pallier? La coopération et la compréhension de la famille sont des facteurs tellement importants pour la réadaptation du malade, que dans son intérêt, l'infirmière visiteuse se doit de les lui assurer.

Au retour du patient au foyer, l'infirmière visiteuse a de bien grandes responsabilités. A elle surtout, échoit la surveillance de sa santé, à cette période si délicate de transition. Surveillance vigilante s'il en fut, car ce patient semble bien, mais cette santé fraîchement recouvrée est mise à rude épreuve, et l'infirmière doit tenir l'oeil ouvert pour déceler la moindre défaillance.

Veiller sur la santé du patient, c'est à dire, veiller à ce qu'il prenne le repos nécessaire. A l'hôpital, c'était chose facile, l'ambiance s'y prêtant, mais au foyer, la chose est tout autre, et le patient sollicité et présumant de ses forces, en abuse parfois. Veiller sur sa santé, c'est encore veiller sur sa diète qui doit se maintenir adéquate, même avec un budget réduit. Veiller sur la santé du patient, cela veut aussi dire, lui éviter toute anxiété inutile, c'est lui aider à solutionner ses problèmes, et là, nous touchons au point névralgique. Le patient est-il sans ressources pécuniaires comme cela se présente à peu près régulièrement? L'infirmière visiteuse, sans tarder, doit le référer à l'institution susceptible de l'aider: "Bien-Etre social", "Bureau d'Assistance sociale aux Familles", etc., mais l'aide ne vient qu'avec le temps. Il y a enquête, vérification, etc., et si le besoin se fait urgent, le diriger vers la Croix de Lorraine solutionnera le problème. En ce cas, l'important est d'agir vite, afin de soulager le pauvre patient que l'angoisse tenaille au point, souvent, de compromettre sa santé, pour peu que cet état de chose se prolonge.

Veiller sur la santé du patient, cela veut encore dire pour l'infirmière visiteuse, le comprendre, l'encourager et l'aider s'il a de la difficulté à s'adapter, lui faire comprendre que c'est une

Mlle Côté est une infirmière visiteuse du Service de Santé, Montréal.

réaction normale, que c'est le lot de tous ceux qui ont à se réadapter, mais que c'est une période passagère et qu'il en sortira vainqueur pour peu qu'il conserve son courage et son optimisme. Elle ne perd jamais l'occasion qui s'offre pour faire comprendre au patient qu'il s'agit là d'une expérience. et qu'il doit dans l'avenir considérer chacun de ses problèmes sous cet angle.

Veiller sur la santé du patient, c'est encore, au besoin, le convaincre de prendre l'exercice préconisé et les distractions permises, afin d'éprouver sa résistance et de récupérer sa force musculaire en vue de son prochain retour au travail.

Pour faciliter ce retour du patient au travail, l'infirmière visiteuse, soucieuse de lui épargner déconvenues et rechutes, fait avec lui l'inventaire de ses capacités et possibilités, lui évitant ainsi de prendre un travail inadéquat qui pourrait avoir de si funestes conséquences sur sa santé, sans compter tout ce qui lui en coûterait d'émotion!

Surtout, elle doit détruire chez ce patient, cette hantise de la rechute car pour plusieurs, retour au travail et rechute semblent être synonymes. Les preuves convaincantes ne manquent pas pour détruire ce préjugé: sur 103 patients, environ, placés par La Croix de Lorraine en 1950, je crois, ne m'a-t-on pas dit récemment, que 4 seulement avaient fait une rechute, et encore, l'une de ces rechutes était probable. Quant aux autres, bien souvent, la faute en était imputable à un manque de coopération de la part de ces patients. Dans une autre institution de Montréal, où l'on s'occupe très activement de la réadaptation des anciens tuberculeux, l'on constate environ 1 rechute sur 8: encore là, cette rechute pourrait être évitée dans bien des cas, si le patient faisait sa part.

L'infirmière s'emploie aussi à détruire chez le patient cette phobie non moins déprimante que tous entretiennent des craintes à son sujet.

Elle doit l'aider à regarder la situation réelle, évitant tout enthousiasme exagéré. De préférence, elle dirige le patient vers le métier qu'il exerçait antérieurement, lui évitant ainsi l'anxiété et la fatigue que nécessite toute rééducation.

Peu de métiers sont à rejeter à priori; l'ambiance dans notre siècle de modernisme comptant plus que le métier lui-même. Ainsi l'étudiant, la ménagère, le commis de bureau retourneront à leurs occupations antérieures. A ce propos, permettez-moi de vous parler du cas suivant réadapté par une infirmière de notre clinique: Il s'agit d'un comptable d'âge moyen, père de 4 enfants, et dont la coopération de même que celle de sa famille nous sont acquises. Sorti du Sanatorium avec congé médical et porteur d'un pneumo, ce patient ne pourra retourner à son travail antérieur d'ici plusieurs mois, quoique nous sommes assurés de l'entière coopération de son patron. Il s'agit d'une rechute et cette fois, l'on redouble de précautions.

Après maintes démarches, l'infirmière a obtenu pour ce patient $160.00 par mois en secours. Ce n'est pas là fortune, mais la famille peut boucler son budget et s'en accommode. Ce cas a été référé à La Croix de Lorraine qui s'occupera de lui procurer un léger travail de comptabilité à la maison. En attendant, l'infirmière visiteuse s'emploie à vaincre chez lui toute crainte de rechute, et l'espoir d'une santé meilleure et d'une vie normale anime le patient.

Là où le travail de l'infirmière visiteuse se complique et où elle peut aider davantage son patient, c'est surtout lorsque celui-ci doit être rééduqué dans un autre métier. Dans ce cas, il faut tenir compte des acquis du passé, c'est-à-dire choisir le métier le plus apparenté avec celui exercé précédemment, tenir compte des aptitudes du patient et aussi de la préparation acquise au Sanatorium. Incidemment, je visitais récemment une de nos grandes institutions sanatoriales et je fus très heureuse d'apprendre que nos patients peuvent y suivre des cours post-scolaires de tous genres, cours conduisant même à l'obtention d'un brevet. Initiative à louer, n'est-ce pas?

Voici un cas typique de réadaptation accompli par l'une de nos infirmières: une jeune ouvrière sortie du sanatorium avec congé médical après thoraco, ne pouvait, de l'avis de son médecin,

retourner à l'atelier, et devait prolonger de deux ans encore son repos au foyer. Elle appartenait à un milieu pauvre mais où il y avait bonne entente dans la famille et bonne coopération. Le père était mort et la mère, brave et courageuse personne, ne quittait pas son fauteuil d'invalide. Et j'en viens au noeud du problème: cette famille n'avait pour tout moyen de subsistance que l'aide des "Mères nécessiteuses", toute autre lui étant refusée. L'infirmière réussit à obtenir du secours pour cette patiente et par des prodiges de débrouillardise, elle réussit à assurer à cette famille, un revenu suffisant pour que cette patiente puisse se reposer le temps prescrit par le médecin. Puis, permission de reprendre le travail étant donnée, l'infirmière conseilla un travail à temps partiel comme vendeuse dans un magasin de lingerie pour dames. Au début, elle ne travailla que quelques heures l'après-midi en fin de semaine seulement, puis progressivement, avec permission du médecin, et sous l'oeil vigilant de l'infirmière, elle augmenta ses heures de travail jusqu'à journée complète. Aujourd'hui, cette personne travaille depuis 3 ans et depuis un an est devenue gérante du magasin.

Parfois l'infirmière visiteuse a encore des problèmes plus épineux à résoudre, tel le cas de ce brave père de famille sorti avec congé médical au début de cette année et à qui le médecin déconseille tout travail pour plusieurs mois à venir. Récemment l'infirmière constate chez lui une anxiété et une nervosité extrêmes, et pour cause: le Bien-Etre social refuse toute assistance prétextant que le père de ce patient peut prendre charge de sa famille. De fait, celui-ci jouit d'une certaine aisance, mais voilà, il refuse péremptoirement d'aider son fils. Que faire? L'infirmière soumet le cas au médecin et on en vient à un compromis: Après examen médical de contrôle, il fut décidé que le patient, ancien voyageur de commerce, retournerait à son travail, limitant la durée de celui-ci au strict nécessaire, c'est-à-dire que lorsque sa subsistance et celle de sa famille seront assurées, Monsieur se reposerait jusqu'à la semaine suivante. Sitôt dit, sitôt fait, la situation est trouvée mais ne devient vacante que dans quelques semaines. D'ici là, ce patient est devenu chauffeur privé pour quelques heures chaque jour.

Après le retour du patient au travail, l'infirmière visiteuse toujours à l'affût continue de veiller sur sa santé. Au besoin, elle lui rappelle qu'il est temps de se présenter pour son examen médical, lui dispense les conseils jugés nécessaires sur son alimentation, sur l'hygiène, etc. Le rôle de l'infirmière visiteuse envers le patient sorti avec congé médical en est un de profonde humanité. Aider l'humain à se guérir, lui insuffler le désir d'être quelqu'un dans la vie, malgré un certain handicap physique, lui apprendre à dépasser sa maladie, à accepter les limitations qu'elle impose, le rendre indépendant, capable de se suffire à lui-même et de reprendre les responsabilités inhérentes à la vie sociale, voilà le rôle de l'infirmière visiteuse.

OFFICIALESE

Committee: A group of the unfit, appointed by the unwilling, to do the unnecessary.

Clarification: Filling in the background with such detail that the foreground must go underground.

Conference: A place where conversation is substituted for the dreariness of labor and the loneliness of thought.

Expedite: To confound confusion with commotion.

Referred for appropriate action: The hopeful attempt to find someone who knows what to do about a hot potato.

Team approach: Many doing the work of one, and all calling signals.

Marion Lindeburgh's Corner

A Professional Challenge

2. The Ascent of Everest — an Analogy

The first article in this series presented an analogy which should afford discussions relating to nursing achievements and progress. To receive the benefit of this analogy, we shall think of ourselves as climbers attempting to reach the summit of our objectives. As we press onward and upward we shall evaluate ourselves in terms of those essentials which brought the Everest expedition to the top.

POSSIBLY THE FIRST REACTION of those who reflect upon this proposal to evaluate ourselves would be that nurses have been so-called mountain climbers for a very long time and there is much in the way of achievement to their credit already. Unlike the Everest climbers we are not starting from the very bottom of the mountain. Very well then, we are at a "base camp," somewhere up the slope. We have had some hard shuffling through the years to get there, and we would like to pause and reflect upon our most important achievements this far. This perusal should provide stimulation and encouragement to continue the climb with greater determination and renewed courage.

Such an exposé might suggest the necessity of a review of nursing history, but a lengthy build up is not the intention. Assuming that nurses today are acquainted with the evolutionary stages of nursing, it would seem more appropriate and more to the point to make some deductive observations sufficient to bring to light present-day significant trends and developments. It should indicate, too, the forward thinking of the nursing profession in pursuit of greater accomplishments in the future.

To fulfil this idea it is decided to utilize material contained in a few of the latest issues of our national nursing *Journal*. Other nursing periodicals could be used also to good advantage (we shall use them later) but as *The Canadian Nurse* is prepared particularly for us and as subscribers and contributors it belongs to us, the thought is that readers of the *Journal* who derive the worth of its content are likely to recall the context and significant features of the articles from which excerpts will be selected. If the recall should be hazy, *The Canadian Nurse* on the library shelf is available for perusal.

Let us begin with the March, 1954 issue. Upon opening the magazine we see the title, "The Long Arm of the Nurse." You have read it for sure. This title in itself suggests a reaching out, an expansion of community service with emphasis upon the increasing functions of the public health nurse today, and of all nursing practitioners. The inclusion of the mental as well as the physical needs of individuals and families, has become a recognized nursing responsibility. The role that nurses now are filling in the "mental health" field represents a big achievement.

In reference to this article the editor of the *Journal* makes a pertinent comment regarding the older and traditional term "hygiene" versus the modern term "health." Those who pioneered in the field of public health nursing, in social work, and in industry will fully appreciate her remarks. A *concept* must become changed before there is *functional* change, and so, at last, the stinted conception of health under the term "hygiene" has given way or has been replaced by the term "health."

The conception and definition of health as formulated by the World Health Organization has opened to nurses a worldwide, indispensable health service of large dimensions to

all mankind. The opportunity and privilege to play an important part in the promotion of health marks another significant achievement.

Other articles entitled "Mental Lectures for Student Nurses," "Public Health Nursing and its Impact on Student Nurses," are indicative of the broader basic preparation necessary for the general practice of nursing. We agree that it is a much needed curriculum adjustment — and so another achievement.

"Nursing Profiles" always draws attention. We like to know who is who and why. The appointment of a "Chief Nursing Consultant" to the Department of National Health and Welfare is a welcomed announcement. It is an appointment to be highly commended. It will bring about many favorable outcomes — better "national" understanding of the aims and functions of the nursing profession, increasing sponsorship and greater cooperation of government officials and departments. Let us hope, too, that through this new contact increasing financial support will be forthcoming in assisting nurses and nursing to be of greater national value. Yes, we *are* growing in stature, status and ability to render a much better public service.

We welcome articles appearing periodically by the nursing director of the World Health Organization, recording nursing experiments and achievements on a world basis. Since the WHO came into being nurses have been appointed to important and difficult positions in many countries, as well as acting on committees. The Expert Committee on Nursing Service is one of several affording members an opportunity to meet with a wide representation of other "experts" to discuss adjustments and possible solution of problems for which the committee was formed. These articles are good for us at home. They help us to visualize nursing as a world service, demanding special qualifications and experience — an incentive indeed to nurses to push on to become eligible for increasing nursing responsibilities at home and abroad. The necessary incorporation of nursing in a world health plan may well be viewed as perhaps the most promising forward step in modern nursing.

A recent publication of excerpts from Canadian press clippings issued from our National Office contains a heading, "World Health Day." Under it we note this statement:

> In observances which have been held this year in various parts of the globe in honor of World Health Day, attention has been particularly centred on the indispensable role played by nurses. This was in keeping with the basic theme of WHO Day — "Nurse, the Pioneer of Health."

Such statements are encouraging and uplifting — they imply a greater professional challenge. The April issue of our *Journal* greets us in its editorial with an arresting title, "The Spirit of Achievement." Let us read the article again, because it is so closely related to our theme, "The Ascent of Everest." The first paragraph contains a wealth of meaning and promise for the future, formulated by a thoughtful writer, and so neatly expressed. The following are excerpts:

> Let us think together, measure things accurately, accept habitually our responsibilities as members of a profession, and go forward in the spirit of achievement (this is a suitable or appropriate description of the procedure and spirit of the Everest climbers!).
>
> Through the years nursing has come through four cycles — apprenticeship, expansion, regulation and standardization, and critical analysis. The yesterdays have brought us to the threshold of achievement; the tomorrow will bring fulfilment of our vision and dreams.

Years ago Miss Adelaide Nutting expressed the same philosophy. She said:

> When young nurses go into action, the dreams of old nurses come true.

Another excerpt:

> The future of nursing depends upon the vision we have for our own future and upon our ability to guide, encourage and direct our students towards being complete students. Encouraging students to master a body of knowledge and certain skills is not enough.

Teachers and supervisors of student nurses would welcome the opportunity of completing the above statement as to what *are* the complete requirements. We thank the writer for what she has said to us; it will help us to climb our Everest.

What announcement in this issue of the Journal warmed our hearts? Great and difficult tasks can bring their rewards. Nurses throughout the world are coming into the limelight; it is good for the world and good for us as a profession since we want to be better known. We are happy that the indefatigable executive secretary of the International Council of Nurses has received a well merited and high honor.

This article has occupied a maximum of space; thus the completion of observation from the remaining latest issues of The Canadian Nurse will need to wait until we meet again in December, almost time to say Merry Christmas!

Foot Note: The writer is conscious of the fact that this article contains little that is original on her part; but if it provided an interview through the avenues within the *Journal*, which will create a greater urge to climb farther up the lofty Everest, the aim has been accomplished.

(to be continued)

In the Good Old Days

(*The Canadian Nurse* — OCTOBER 1914)

A WORKING COMMITTEE was approved by the Canadian National Association of Trained Nurses to study the question of integrating all the various branches of nursing into one large association. In 1914, the Superintendent's Society and the Public Health Nurses' Association functioned as entirely separate bodies.

* * *

"Nurse training is not a sufficiently educative course, because: (a) it does not develop character as well as it should; (b) it does not fully fit the women for the practice of their profession. The course at present has a tendency to prevent the broad development of the whole woman, and, on the professional side, trains only in hospital nursing."

* * *

"I favor a well-mapped-out preliminary course for student nurses, taking in the scientific subjects, and then spending two years in the hospital having the instruction necessary in the art of discipline. You may know how to do a thing thoroughly when you have done it five or six times but continual drilling in it is a necessary discipline. This may seem useless and unnecessary but it helps the nurse to do the right thing, to do it well, and it relieves her mind of the strain of doing a task."

"There is a good deal of talk these days of the high cost of living. The man with the moderate salary finds his cheque scarcely sufficient for ordinary needs. When sickness comes, he finds it impossible to pay a private nurse's fees."

* * *

"Children will be willing to go to a dentist when the school nurse makes a bargain with them to cure the warts of every child who has teeth filled."

* * *

"The function of the visiting nurse is more than to give care during illness. If she is to fully realize her opportunities she must be a woman of broad social training and at the same time be thoroughly skilled in the details and practice of her profession."

* * *

According to a report given at the convention of the C.N.A.T.N. there were 307 nurses engaged in some branch of public health nursing in Canada in 1914.

People can be placed in three classes: the few who make things happen; the many who watch things happen; and the overwhelming majority who have no idea what has happened.

News and Echoes

from

Your NATIONAL OFFICE

Wherever You Are!

IF THERE IS ANYONE who can tell us how to keep track of eighty-seven young and active nurses, our sincere gratitude will be forthcoming. In July, National Office prepared and sent out a questionnaire to all the graduates of the Metropolitan School of Nursing demonstration project. The post office tried diligently to deliver these but found that some had moved on without leaving a forwarding address. If any of these graduates did not receive a questionnaire, please write to National Office giving us your present address.

So far tabulations have not been done as all the replies are not in, but the indications are that our "C.N.A. Alumnae" have been absorbed into many different branches of nursing. Marriage, of course, has claimed a good proportion but many of these are combining the two careers.

Head Nurse Study

Word has been received from Ottawa that the report of "A Study of the Functions and Activities of Head Nurses in a General Hospital" is now almost ready for distribution. This study was planned and conducted by the research Division, Department of National Health and Welfare, at the request of the C.N.A. and carried out at the Ottawa Civic Hospital. The interim report released some time ago was just a sample of the excellent material in the final report.

History in Color

Student nurses, present and future, will enjoy the film strip "Florence Nightingale and the Founding of Professional Nursing" prepared by the Metropolitan Life Insurance Company. It is a 35 mm. sound film strip in color, running 15 minutes. The script which accompanies it is available on a 33⅓ r.p.m. record, or in print for reading. The strip was shown at the Biennial Meeting in Banff but, owing to the many other activities, to a very limited audience. Requests for loan, without charge, should be directed to:

Health and Welfare Division,
Metropolitan Life Insurance Co.,
Ottawa, Ontario.

Ontario Takes Stock

In 1953 the Nursing Branch and the Division of Medical Statistics of the Department of Health for Ontario undertook a survey of hospital nursing services. The results of this survey have now been released and provide some interesting information. Part of the introduction will indicate the material contained in the data collected.

"Methods and Scope of the Survey:

The Survey was carried out by direct questionnaire. The survey form (Appendix A) included three types of information:

1. *Part A* — Inventory of Nursing Personnel.

The information sought here was the quantity and quality of nursing service in terms of the number and types of personnel according to function and in relation to the number of patients.

2. *Part B* — Pre-Employment preparation of Non-Registered Auxiliary Nursing Personnel.

Information was sought about the quality of nursing service in terms of preparation of the worker.

3. *Part C* — Training Courses for Auxiliary Nursing Personnel.

Information was sought about courses leading to a diploma or certificate not recognized under existing legislation. In addition information was sought about in-service training to discover whether centres for supplementary courses were indicated to prepare these employees for certification.

The survey covered a total of 264 hospitals in Ontario."

Nouvelles et Echos

Où que Vous Soyez!

QUELQU'UN POURRAIT-IL nous dire comment retracer les quatre-vingt-sept jeunes et actives infirmières que nous cherchons? Notre reconnaissance lui est assurée. En juillet le secrétariat national a préparé et adressé un questionnaire à toutes les diplômées de l'école expérimentale Metropolitan de Windsor. La poste, avec toute la diligence qu'on lui connait, a essayé de remettre les lettres, mais il y en avait de déménagées sans laisser d'adresse. Si quelques-unes de ces diplômées n'ont pas reçu notre lettre, nous les prions de nous écrire.

A date la compilation des renseignements n'a pas été faite, toutes les réponses n'ayant pas été reçues, mais nous pouvons déjà dire que ces infirmières se sont dirigées vers diverses branches du nursing. Plusieurs, naturellement, sont mariées et quelques-unes mènent de front deux carrières, se dévouant aux soins des malades et au bien-être de leur famille.

Etude sur les Fonctions de l'Hospitalière

Nous recevons un mot d'Ottawa, nous disant que le rapport sur "L'Etude des fonctions de l'Hospitalière (head nurse) dans un hôpital général" sera prochainement publié. Cette étude a été préparée et dirigée par le Service des Recherches du Ministère de la Santé Nationale et du Bien-Etre, à la demande de l'Association des Infirmières canadiennes et faite à l'Ottawa Civic Hospital. Le rapport provisoire, publié il y a quelque temps, nous a donné un échantillon de la qualité du rapport final.

Un Film en Couleur sur l'Histoire

Les étudiantes actuelles et futures de nos écoles d'infirmières verront avec plaisir le film préparé par la compagnie Metropolitan Life Insurance intitulé, "Florence Nightingale et la Création du Nursing Moderne." Ce film, sonore et en couleur, est un 35 mm., il dure 15 minutes. L'on peut se procurer le texte soit sur disque, de 33⅓ r.p.m. ou pour lecture, sur feuillets. Cette bande courte a été montrée au Congrès de Banff, mais à cause de nombreuses autres activités, l'auditoire était restreint. Pour obtenir ce film gratuitement l'on doit écrire directement à:

Division de la Santé et du Bien-Etre
Compagnie d'Assurance Metropolitan Life
Ottawa, Ontario.

L'Ontario fait son Examen

En 1954, la division du Nursing et la division de la statistique médicale du ministère de la Santé de l'Ontario entreprirent de faire le relevé des services hospitaliers. Les résultats de cette enquête viennent d'être publiés et donnent d'intéressantes informations. L'introduction indique les matériaux employés "Méthode et Plan de l'Enquête.

Le relevé fut fait au moyen de questionnaires envoyés directement aux institutions, et ayant pour but d'obtenir des renseignements sur trois points.

1. *Partie A* — Inventaire du personnel donnant des soins aux malades.

Les renseignements désirés se rapportaient à la quantité et à la qualité des soins donnés en raison du nombre et des diverses catégories du personnel, des fonctions de chacune et du nombre de malades.

2. *Partie B* — Préparation reçue par le personnel auxiliaire non enregistré.

Les renseignements désirés se rapportaient à la qualité du service donné en raison de la préparation reçue par l'auxiliaire.

3. *Partie C* — Cours pour Auxiliaires.

Les renseignements désirés se rapportaient aux cours donnant droit à un diplôme ou à un certificat, lequel n'est pas reconnu pour l'enregistrement. En plus l'on demanda des informations sur l'entraînement donné sur place, afin de se rendre compte s'il n'y aurait pas lieu d'ouvrir d'autres centres où le cours, permettant aux auxiliaires d'être légalement reconnu, serait donné.

Le rapport donne la compilation de renseignements fournis par 264 hôpitaux de l'Ontario."

Inscription on the Anatomic Theater in Paris: Hic locus est, ubi mors goudet succurrere vitae. (This is the place where death is glad to assist life).

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Student Nurses

Abdominoperineal Resection

ROBIN KLAEHN

MR. GOWAN was admitted to hospital on April 14, for investigation of a mass in the rectum. He was 54 years old, had enjoyed good health, an active life, and now appeared to be in moderately good physical condition. Although obviously concerned about his hospitalization, he displayed geniality and a willingness to cooperate with the medical and nursing staff.

A year previously he had been admitted for a herniorrhaphy, from which he had made an uncomplicated recovery. Since that time his appetite had become progressively poorer, and in the last three months he had lost 25 pounds. On admission he weighed 178 pounds.

About two months prior to this admission, Mr. Gowan began to have intermittent, crampy lower abdominal pain, accompanied by mild indigestion. At approximately the same time his bowel habits, previously normal, became increasingly irregular, until, in the past few weeks, he had been having five or six loose bowel movements daily, with frequent passage of bloody mucus, usually in the morning.

Digital examination of the rectum by the family physician one week before admission, revealed a hard mass on the anterior aspect of the rectum, about five inches from the anus. The physician advised hospitalization and further investigation by a specialist.

Mr. Gowan was a man of average means, and his medical and hospital expenses were adequately covered by a reliable medical care plan. Therefore the financial problem of hospitalization was not acute. However, he was a widower with a teen-aged son and daughter dependent on him. Although he attempted to conceal his concern over his condition, it was evident that he feared the outcome of the investigation. Tact and encouragement were needed on the part of both doctors and nurses to allay this fear.

The diagnosis on admission was possible carcinoma of the rectum.

Miss Klaehn is a senior student at the General Hospital, Hamilton, Ont.

ANATOMY OF THE ORGANS INVOLVED

The large intestine is about five feet long, two and a half inches in diameter. It extends from the ileum to the anus and is divided into four parts:

(a) *Cecum and vermiform appendix* — The small intestine opens into the side wall of the large intestine about 2½ inches above the beginning of the large intestine. This section of bowel forms the blind pouch called the cecum. The appendix is a narrow tube attached to the end of the cecum.

(b) *Colon* — The initial portion ascends on the right side of the abdomen until it reaches the under surface of the liver, where it bends abruptly (hepatic flexure) and continues across the abdomen as the transverse colon. At the left side it curves beneath the lower end of the spleen (spenic flexure) and passes downward as the descending colon. Reaching the iliac region on a level with the crest of the ilium it makes a curve like the letter "S" forming the sigmoid colon, which ends in the rectum.

(c) *Rectum* — This part is about five inches long and is continuous with the sigmoid colon and anal canal. From its origin at the third sacral vertibra, it descends downward and forward along the curve of the sacrum and coccyx, bending sharply backward into the anal canal.

(d) *Anal Canal* — This is about one to one and a half inches long. The external aperature is called the anus, guarded by external and internal sphincter muscles.

The functions of the colon are to

absorb fluids; to complete the digestive processes of the small intestine; to serve as an avenue of elimination for waste materials from the body.

Pathology

A malignant tumor grows by invading the surrounding tissues. It travels along the blood and lymphatic vessels, extending rapidly by these means as tumor cells are broken off and carried to other parts of the body. This secondary growth is called a metastic growth.

Because carcinomas invade the surrounding tissues in a crab-like manner, complete removal is nearly impossible without radical excision of the entire organ and adjacent lymph nodes. Carcinomas sap the strength of their host resulting in weight loss.

On April 15 Mr. Gowan underwent a sigmoidoscopic examination. A biopsy of the mass revealed malignancy. Microscopic examination of the cells showed polypoid adenocarcinoma, with the cells invading the muscle coat. Therefore, excision of the descending colon and adjacent lymph nodes was recommended.

At operation on April 23 the specimen sent to the laboratory consisted of the anus, rectum and terminal portion of the sigmoid. Nodular glands were palpated separately from the infiltrating portion of the carcinoma, proving that metastasis to adjacent lymph nodes had already taken place. These nodules were sectioned and two out of three revealed malignancy. The pathological diagnosis confirmed adenocarcinoma of the rectum and lymph node metastasis.

Pre-Operative Preparation

Mr. Gowan was hospitalized for eight days prior to surgery. His preoperative preparation may be considered from four aspects:

(a) Diagnostic procedures and introduction to hospital life.

(b) General physical preparation.

(c) Specific preparation of the colon.

(d) Mental preparation.

Diagnostic procedures and introduction: Arriving on the surgical ward, Mr. Gowan was met by the nursing staff who, by their welcome, assured him of their kindly interest in his welfare. He was taken to a sunny, four-bed room and introduced to the other patients who were convalescing from surgery.

The surgeon visited him in the evening, explained the biopsy and sigmoidoscopic examination to be done the following morning, and ordered a mild hypnotic, tuinal gr. 1½ to ensure a good night's sleep.

Two days later Mr. Gowan underwent a barium enema x-ray examination to rule out further carcinoma of the upper bowel. Preparation for this included castor oil the previous afternoon, a fluid supper, nothing to eat, drink or smoke after midnight, and a colon irrigation the morning of the test, followed by a light breakfast.

Laboratory investigation:

Hemoglobin — 82% — 12.3 gm./cu. mm. of blood — good.

R.B.C. — 4,600,000/cu.mm. of blood — normal.

W.B.C. — 13,600/cu.mm. of blood — slightly elevated.

Sedimentation rate — 5 mm./hour — normal.

Blood chemistry: 12.0 mgm./100 cc. blood — normal urea nitrogen.

0.104 mgm./100 cc. blood normal for blood sugar.

Urinalysis: revealed mucus and a few pus cells, otherwise it was normal.

He was also crossed and typed for 3,000 cc. of whole blood to be on hand for the operation. The date for surgery set as April 23.

General physical preparation: Mr. Gowan's general health was good. He was placed on a high calorie, low residue diet to rest the colon and maintain a high level of nutrition. Rest and recreation then played an important role in keeping him in a satisfactory physical condition.

A retention catheter was inserted the evening prior to surgery. He was given nothing by mouth after midnight. A quiet and cheerful atmosphere was maintained in the morning hours before the operation in order that Mr. Gowan could benefit to the fullest from his sedatives.

Specific preparation of the colon: The low residue diet provided minimum activity of the bowel for the week prior to surgery. Mineral oil was given twice a

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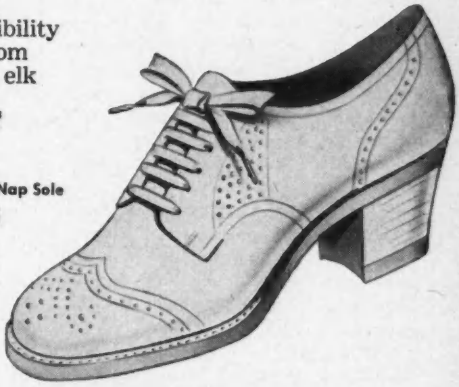

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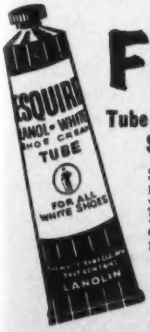

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day to keep the flow regular through the partially obstructed bowel.

To decrease bacteria in the intestinal tract, Sulphaquanadine gr. 7½ q.4 h., was ordered for five days pre-operatively, with gr. 30 to be given at 6:00 p.m. the evening before the operation.

A colon irrigation was given the evening prior to surgery, and his abdomen, perineum and buttocks were shaved.

Mental preparation: The cheerfulness, consideration and interest displayed by the nursing staff and hospital personnel did much to alleviate Mr. Gowan's apprehension. The surgeon carefully explained the surgical procedure, its necessity and the probable results in lay terms. He emphasized the fact that the colon was obstructed, and if this continued it would undermine the general health. He explained that a colostomy did not mean invalidism, but that a well cared for colostomy functioned well, causing very little discomfort or trouble. Mr. Gowan's personal and business life would be in no way impaired, and a moderate life expectancy could safely be anticipated with surgery. The careful and tactful manner in which this was told gave the patient confidence in his surgeon.

Before the day of operation, the anesthetist also visited Mr. Gowan, told him the type of anesthetic he would receive, and checked his heart and lungs. He also reassured him that adequate pre- and post-operative sedatives would be given to ensure him of maximum freedom from pain and discomfort.

Because Mr. Gowan was an intelligent man, interested in his condition and its cure, he was introduced to another patient on the ward who, after a similar operation, had had a well functioning colostomy for 12 years. This gave Mr. Gowan the hope that he too would be able to manage his colostomy successfully in the future.

During this week, Mr. Gowan received a visit from his pastor, talked with him in the privacy of the sun-porch, and appeared quite contented afterward. Thus this patient went to surgery in a quiet and confident frame of mind because he had faith in God, confidence in his surgeon, the medical and nursing staff, and confidence in his own ability to manage this physical change satisfactorily in the future.

Operative Procedure

The operation began at 8:05 a.m. A lower midline incision was made. A large carcinoma of the upper rectum was attached to the prostate. The sigmoid was sectioned at its midpoint, the lower sigmoid and rectum were mobilized, and the pelvic floor reconstructed. The proximal end of the sigmoid was brought out through a gridiron incision on the left side as an end colostomy. The peritoneum was dusted with sulphathiazole powder to prevent infection from possible contamination. The incision was closed in layers without drains. The rectum was resected through a perineal incision. The wound was closed and packed with gauze, which was placed in an oiled silk envelope for protection of the tissues. Whole blood, 500 cc., was started at 9:00 a.m. to replace that lost during surgery and to prevent shock. The operation finished at 10:50 a.m.

Post-Operative Treatment and Nursing Care

Immediately after surgery Mr. Gowan was taken to the recovery room. Because of a light general anesthetic he became semi-conscious almost immediately and his color and general condition were noted as satisfactory. A second 500 cc. of blood was running well in his left arm. Oxygen was administered by nasal catheter to combat possible shock. He was placed on his right side with a pillow supporting his back.

At 11:10 he became conscious and complained of severe pain in the operative area. Morphine sulphate gr. ¼ was given to relieve pain and restlessness, and he was then turned on his left side.

At 12:10 he was seen by the houseman and the dressings checked. As there was considerable sanguineous drainage from the perineal incision, the dressing was reinforced.

At 12:30 Mr. Gowan was returned to the ward, where a nurse remained with him to ascertain his general condition. The dressing was again checked. The urethral catheter was attached to a gravity flow irrigation. Almost immediately he settled into a light sleep.

At 3:00 p.m. Mr. Gowan became very restless and nauseated. He frenquently vomited greenish fluid. His color became markedly pale and diaphoresis was troublesome. The houseman was called and Hykinone 72 mgm. was given intravenously to combat hemorrhage. A levine tube was passed and Wangensteen drainage begun to relieve the nausea and possible distention.

When the blood was absorbed, 1,000 cc. of 5% glucose in distilled water was started to maintain his fluid balance while he was unable to take fluids by mouth.

Two nurses prepared Mr. Gowan for the night. The perineal and abdominal incision were re-dressed. There was moderate drainage now from the perineal wound. The levine tube was irrigated and was draining well. Special mouth care was needed to protect the mucous membranes of his nose and throat from irritation by the levine tube. This care included methol and albolene nose drops, alkaseptine mouth wash, and Mandel's pigment applied to the back of the throat. The intravenous was running well at 40 drops per minute. Both Wangensteen and intravenous were then checked q.2 h., and the catheter irrigated q.4 h. Mr. Gowan was encouraged to breathe deeply and move his legs about freely. Seconal gr. 1½ was given as a hypnotic to ensure sleep during the night.

On his first post-operative day, Mr. Gowan was very restless. Morphine sulphate gr. ¼ was given q.4 h., p.r.n., to relieve the intense pain and to keep him fairly quiet. Diaphoresis during the night had been severe and a quick sponge bath was included in his morning care. During the day his temperature rose to 101.4° F.

Intravenous injection of 2,000 cc. 5% glucose in distilled water and 1,000 cc. of 5% glucose in saline was absorbed during the day. The same amount was ordered to be given daily. Medication for the first three post-operative days included:

Ascorbic acid, 1,000 mgm. I.M. daily to promote healing; B-Plex 2 cc. I.V. daily for nutritive value; Fortimycin 3 cc. I.M. b.i.d. (procaine penicillin 400,000 units and streptomycin 1 gm.) to combat infection.

A zeroform dressing was applied to the colostomy and dry dressings to the abdominal and perineal incisions q.4 h. Mr. Gowan moved about well, breathed deeply. He coughed up a considerable amount of mucus.

On the second post-operative day, a moderate amount of watery fecal material was passed through the colostomy. Copious serosanguineous drainage was found on the perineal dressing.

On the third morning, although he was moving well, the patient's abdomen was distended with gas. A hot water bottle (135° F.) was applied to his abdomen. Scant, watery fecal drainage continued from the colostomy opening. His progress to date having been satisfactory, the levine tube was removed and the intravenous discontinued. A full fluid diet, as tolerated, was ordered. Ascorbic acid and B-Plex were now given orally. With the removal of his "tubes," Mr. Gowan brightened considerably.

The colostomy was first irrigated on the fourth post-operative day and a great deal of flatus with much fluid fecal material was expelled. The patient was much more comfortable afterwards. The colostomy was trimmed by the surgeon with electro-cautery and a regular colostomy dressing applied.

The perineal packing was also removed, resulting in profuse drainage. The doctor left an order for the sinus to be irrigated by catheter, with water, saline, and Hygeol 1:12 by the houseman b.i.d. for two days, then daily. Mr. Gowan was allowed to sit on the edge of his bed and felt that now the road to recovery was in sight.

Convalescent Care

As each day passed, Mr. Gowan steadily gained in strength and spirits. He became increasingly active, first sitting for a few minutes in a chair, and later walking short distances. His diet was gradually increased to a full low residue diet and then to a regular diet.

Instruction was begun on the management of the colostomy. A Bowman irrigator and dressing equipment were given the patient, and the nurse explained the method and purpose of the irrigation while doing the treatment.

On the twelfth post-operative day, Mr. Gowan irrigated his colostomy himself, under the guidance of the nurse. He was told that regular irrigation daily or every two days, as it was needed, would keep the bowel functioning well, and that, after a short time, minimum dressings could safely be used during the interval between irrigations.

He learned that his diet need not be restricted, except according to his own desires though moderate amounts of raw vegetables and fresh fruits were advisable.

On may 6 his sutures were removed and Mr. Gowan was up and about the ward, becoming self-sufficient again. By May 9 he had taken over the responsibility of his colostomy, and was allowed to return home, to carry on his convalescence attended every other day by a Victorian Order nurse.

Book Reviews

Dukes' Bacteria in Relation to Nursing, revised by Stanley Marshall, M.D., B.S. (Lond.), M.R.C.S. 205 pages. Clarke, Irwin & Co. Ltd., 103 St. Clair Ave. W., Toronto 5. 2nd Ed. 1953. Price $3.00. *Reviewed by Sr. M. Melanie, Educational Director, School of Nursing, St. Mary's Hospital, Montreal.*

In his revision of the text, Dr. Marshall has followed the original arrangement of subject matter as closely as possible but has made certain changes in order to bring the content into conformity with newer knowledge and opinions and more recent methods.

In the introduction, it is stated that the author primarily intended the book to serve as a guide for sister tutors and other nursing students in preparing for their examinations. In so far as the book might be used as a general review of the subject, I believe that this purpose has been accomplished. However, certain elementary principles have been treated in a rather superficial manner and, for this reason, I do not think that the book would be suitable as a text for the student who has had no previous instruction in bacteriology.

The book is written in a simple and readable style which avoids a multiplicity of technical terms. It is divided into six sec-

tions dealing respectively with: what bacteria are and methods of studying them; classification and description of bacteria; immunity; collection and examination of specimens; sterilization, antiseptics and disinfection; and practical bacteriology. Section II, which deals with the classification and description of bacteria, includes the well known and common varieties and treats of them under the following headings: where found; morphology; cultures; special tests; and resistance. The material in this section is clear and concise and would serve as an excellent reference for students who sometimes have to read through page after page of texts in order to obtain the same facts. I believe the material in this section would have been more valuable if a more definite distinction had been made between true bacteria and other organisms such as the spirochetes.

Section IV, which is devoted to the collection and examination of specimens for bacteriological tests, contains very valuable information for the nurse. This application of scientific principles to nursing procedures and techniques is an aspect which has been somewhat neglected by many authors, and the fact that it has been included here is sufficient to make this book a valuable addition to any nurse's library.

Common Symptoms Described and Explained for Nurses, by C. Allan Birch, M.D. 201 pages. The MacMillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1953. Price $1.65.

Reviewed by Florence K. MacLean, Instructor of Nurses, P.E.I. Hospital, Charlottetown.

Dr. Birch realized the necessity of increasing the interest of nurses in the common symptoms of disease. This very concise book is written in such a manner that it is easily followed and understood by any nurse — student or graduate. One can pick it up at any time and start at any essay — concentrating on the one which is of chief interest at the time. Readers will obtain a clear description of the common symptoms of illness of which some person or patient has complained. I have thoroughly enjoyed reading this book. I feel that I have benefited greatly by doing so and I hope that all nurses will find the opportunity to read it.

Optimist: A person who starts a crossword puzzle with a fountain pen.

Dear Editor

I, like many fellow nurses, have just returned from a wonderful C.N.A. Convention at Banff, but I have come away with such ambivalence that I find it necessary to write to you. I sat throughout the convention in true authoritarian nursing style and never used my voice.

At the present time I am engaged in psychiatric nursing but nursing as a whole, with all its components, is my great love. Now, you will say, we devoted a whole morning to psychiatric nursing and there was accomplishment. What more could she want? Well, we also devoted a whole session to the recruitment of nurses. It was wonderful to hear all the discussion and especially from the students. Some of the students were fine speakers too. However, never in all the discussion was the topic of recruitment of *male* students mentioned . . . Oh, we did not "disinclude" them but neither did we make a point of including them. How much longer are we going to sit back and ignore this very pertinent question? I can hear you saying, "Oh, she's in psychiatric nursing and that is the place for male nurses 'par excellence.' The question is pertinent to psychiatric nursing only."

As far as I can see, we need only to take a look at the male medical and surgical wards. We bring men in off the street, with little or no preparation, and permit them to catheterize, do sterile dressings, irrigations and all sorts of duties and techniques which female nurses spend hours and hours learning. These men, for the most part, get little instruction and, because of our Victorian ideas or ideals, no supervision. What is wrong with us? Have we not grown big enough yet to accept these facts and do something about them? Have we been king in our castle for so long that we think there is some part of nursing that men cannot practise? Do we not realize that men contribute one trend of thought, women another, and that we have much to gain from the contribution of both?

In the past war, male nurses were not given equal status with female nurses. Why? Is the female ranking not equal to the male ranking or was there any just and logical reason? The war has been over quite a few

years but have we done anything about it?

Many will say, look at the type of men we get as orderlies and male nurses. A great many are alcoholics, homosexuals, etc. Well — did not female nursing come through an era of Sairey Gamps and prostitutes, etc. What have we done to help elevate male nursing service? We have progressed, in a very short time, to what we believe is a reasonably high standard of nursing. I am convinced that male nurses with a bit of encouragement and help, would lose little time in attaining the same standard.

Finally, since our first interest, as nurses, is humanity would not male and female nursing services combined make for better psychological relationships and so contribute to the ascent of man?

E.C. — *Not a male nurse.*

A cucumber should be well sliced, and dressed with pepper and vinegar, and then thrown out, as good for nothing.

— SAMUEL JOHNSON

British Columbia

THE FOLLOWING are staff changes in the British Columbia Division of Public Health Nursing:

Appointments — Betty Brasher (Royal Jubilee Hosp., Victoria) to Selkirk health unit, Nelson; *Margaret Imming* (St. Paul's Hosp., Vancouver) to East Kootenay health unit, Kimberley; *Evalyn Greene* (University of Manitoba and McGill University) to Saanich and South Vancouver Island health unit; *Patricia Knowlton* (Vancouver Gen. Hosp.) and *Lula McComb* (St. P. H., Vancouver) both to South Central health unit, Kamloops; *Doreen Pope* (V. G. H. and University of British Columbia) to Skeena health unit, Smithers; *Thiera Sargent* (Regina Gen. Hosp.) to Upper Island health unit, Courtenay; *Betty Hopkins* (Royal Inland Hosp., Kamloops) to Cariboo health unit, Williams Lake; *Miriam Cressman* (reinstated after receiving B.N. degree at U.B.C.) to Skeena health unit, Terrace; *Irene Witt* (St. P. H., Vancouver) to North Okanagan health unit, Vernon; *Iva Watt* (Royal Alexandra Hosp., Edmonton) to East Kootenay health unit, Creston; *Mabel Elliott,*

(City Hosp. and Queen's University, Belfast, Ireland, and Royal Sanitary Institute, London, Eng.) to North Okanagan health unit, Salmon Arm.

After leave of absence to complete public health nursing course: *Shirley Gowe* to South Central health unit, Ashcroft; *Mrs. Phyllis Piddington* to North Okanagan health unit, Vernon; *Marilyn Barber* to Upper Fraser Valley health unit, Chilliwack; *Mrs. Edith Fraser* to Invermere-Golden district of East Kootenay health unit; *Gertrude Rach* to Cariboo health unit,, Vanderhoof; *Letty Watson* to North Okanagan health unit, Revelstoke.

Leave of Absence to complete the public health nursing course — At U.B.C.: *Kathleen Robertson, Vera Andrews, Ruth Chunas, Willa Davies, Marcia Davis, Mary Keller, Evelyn Mitchell, Kerstin Weber;* at McGill U.: *Shireley McKeown, Neda Nickyporouk, Betty Page, Marguerite Perry, Miriam Walmsley;* at University of Toronto: *Helen Pyne.*

Transfers — *Joan Sutcliffe* from North Okanagan health unit, Vernon, to Selkirk health unit, Nelson, and Doris Vosburgh from Cariboo health unit, Prince George, to South Central health unit, Kamloops, as senior nurses; *Leola Carr* after leave of absence to attend U.B.C. to Selkirk health unit, Nakusp; *Vera Andrews* from the Division of Tuberculosis Control and *Mrs. Charlotte Brown* from South Central health unit, Lillooet, both to East Kootenay health unit, Creston; *Audrey Damgaard* from South Central health unit, Kamloops, to Boundary health unit, Cloverdale; *Barbara Vidal* from Upper Fraser Valley health unit, Chilliwack, to South Okanagan health unit, Keremeos; *Doris Widdifield* from North Okanagan health unit, Revelstoke, to West Kootenay health unit, Castlegar; *Bernadine Conroy* from West Kootenay health unit to Peace River health unit, Dawson Creek; *Frances Neighbour* from Skeena health unit, Terrace, to Central Vancouver Island health unit, Lake Cowichan; *Aldred Ker* from South Central health unit, Ashcroft, to Coquitlam area of Simon Fraser health unit.

Resignations — *Mrs. Margaret Calvert* and *Mrs. Margaret Johnson* from North Okanagan health unit; *Phyllis (Harwood) Smith* and *Mrs. Sybil MacFarlane* from South Central health unit; *Beryl Lucas* and *Mrs. Beatrice Gardiner* from Upper Fraser Valley health unit; *Mrs. Estelle Bates* from

Upper Island health unit; *Kerstin Nelson* and *Helene (Byrt) Lacy* from East Kootenay health unit; *Mrs. Margaret Strongitharm* and *Beverley McNair* from Central V.I. health unit; *Marguerite Cusson* from North Fraser Valley health unit; *Mrs. Phyllis Swaisland* from South Okanagan health unit; *Mrs. Ruby Carling, Frances Stewart* and *Mrs. Jean McAllister* from West Kootenay health unit; *Mrs. Cassie Stevens* from Skeena health unit; *Mrs. Eileen Kelly* from Boundary health unit; *Emma Dzubin* from Peace River health unit to accept a position with the Red Cross at Atlin; *Lorraine Carruthers* from South Central health unit to be married.

Vancouver

The following are changes in the nursing staff of the Metropolitan Health Committee:

Appointments — Claire Lambe (M.A., B.S.N., Vancouver Gen. Hosp., Columbia and McGill Universities) to health unit 3, as supervisor. *Gwyneth Jones* (St. Paul's Hosp. and B.S.N., University of British Columbia) to North Shore health unit; *Kathleen Macdonald* (University of Alberta and M.N., University of Washington) to health unit 2; *Marion Macdonell* to health unit 1; *Sheila Ogilvie* (B.A.Sc., B.C., from U.B.C., and M.P.H., University of Manitoba) to health unit 4; all as assistant supervisors. *Joan Doree* (St. Paul's Hospital, Saskatoon, and B.A.Sc., U.B.C.) to the Health Centre for Children, as liaison worker.

Carol Anderson (Oshawa Gen. Hosp. and University of Toronto); *Mabel Birtch* (Royal Columbian Hosp. and U.B.C.); *Judith Bowlby* (Women's College Hosp. and U. of T.); *Ruth Burgman* (Toronto Gen. Hosp. and U.B.C.); *Helen Flinkman* (Royal Alexandra Hosp., Edmonton, and U.B.C.); *Joanne Greene* (Royal Victoria Hosp., Montreal, and U.B.C.); *Melva Hughes* (Swedish Hosp. and B.Sc., U. of W.); *Myrtle Millar* (Holy Family Hosp., Prince Albert, and U.B.C.); *Mrs. Jean McKenzie* (R.V.H., Montreal, and McGill U.); *Jean McMurray* (B.Sc., U. of A.); *Louise Parr* (T.G.H. and U. of T.); *Frances Prestley* (St. Joseph's Hosp., and U.B.C.); *Heather Rose* (Good Samaritan Hosp., Phoenix, Ariz., and U.B.C.); *Margaret Stewart* (V.G.H., and B.S.N., U.B.C.); *Evelyn Teir* (Royal Jubilee Hosp., Victoria, and B.Sc., U. of W.); *Anna Wall* (McKellar Gen. Hosp. and U.B.C.); *Catherine Guimont* and *Patricia*

McInnes, registered nurses, (both St. Paul's Hospital, School of Nursing).

Returned to Staff — *Mildred (Buckler) Burton, Mrs. Aileen Colcleugh, Marion Macdonell, Mrs. Anita Wong.*

Resignations — *K. (Oulton) Banks, Joyce (Read) Camenzind, M. Donevan, Marjorie (McEwen) Inglis, Elsie (White) Kristenson, Marney (McLellan) Mathe, Frances (Turnbull) Phillips, Elaine Radcliffe, F.M. Ross, Mavis (Coleman) Stanfield, Lara Thordarson, M. Veit, E. Williamson.*

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — As nurse-in-charge — Barrie, Ont.: *Frances Cox* (Royal Victoria Hosp., Montreal). Lunenburg, N.S.: *Jean Murray* (Grace Hosp., Windsor). Newcastle, N.B.: *Norma Ruth Brown* (Ontario Hosp., Kingston). Pictou, N.S.: *Margaret McRae* (Ottawa Civic Hosp.). Porcupine, Ont.: *Joan Grimes* (St. Joseph's Hosp., Kingston). Prince Albert: *Margaret Arnett* (Archer Memorial Hosp., Lamont, Alta.). Sherbrooke: *Laurentine Germaine* (St. Joseph's Hosp., Three Rivers). Whitby: *Joan Dubs* (Metropolitan Gen. Hosp., Windsor). Wolfville, N.S.: *Elizabeth Hanna* (Toronto Gen. Hosp.). To staff — Brantford: *Mary Dowling* (Brantford Gen. Hosp.). Hull, Que.: *Rose Therberge* (Hôp. de L'Enfant-Jésus, Québec). London: *Shirley Twamley* (Victoria Hosp., London). Montreal: *Helen Schwartz* (Montreal Gen. Hosp.). Owen Sound: *Nora Lee* (M.G.H., Windsor). Peterborough: *Helen Kennedy* (O.C.H.). St. John's, Nfld.: *Esther Buckley* (St. Clare's Mercy Hosp., St. John's). Saskatoon: *Bruna Zorzes* (St. Joseph's Hosp., Port Arthur). Sudbury: *Carol Hutton* (Calgary Gen. Hosp.). Toronto: *Barbara Bain, Eleanor Cook* and *Beverley Frise* (all V.H., London); *Venetta Kaplanis* (St. Joseph's Hosp., London); *Catherine Lamont* and *Ruth McConaghy* (both University of Toronto); *Eileen Yano* (T.G.H.). Vancouver: *Shirley Ann Slater* and *Margaret Standerwick* (both Vancouver Gen. Hosp.). Waterloo, Que.: *Norma Salmon* (Owen Sound School of Nursing). Weston, Ont.: *Ruby Rechsteiner* (Hamilton Gen. Hosp.). Windsor: *Janet Barnby* (V.H., London).

Reappointment — Vancouver: *Maureen (Little) Barnes.*

Transfers — As nurse-in-charge — *Vera Bruegeman* from Sherbrooke to St. Thomas. *Jean Cummine* from Porcupine to Regina. *Phyllis Farmer* from Prince Albert to Corner Brook, Nfld. *Blanche MacPherson* from Wolfville to New Glasgow, N.S.

News Notes

ALBERTA
DISTRICT 2

PONOKA

In a summary of the year's activities of the district, the following additional events are noted: A successful Christmas party; the entertainment by Miss Morrell and her staff at Municipal Hospital; the presence of Mrs. Clara Van Dusen, provincial registrar, and some members of Westaskiwin Chapter at the March meeting when Mrs. Van Dusen clarified some business points and outlined plans for the C.N.A. biennial convention in Banff; a tea and raffle, a well arranged dance attended by Mrs. Van Dusen and her party from Edmonton and the nomination of J. Grahn, N. MacDonald, Misses Evans and

Groom as delegates to the biennial convention; discussion by Miss Grahn of points in the structure study to be voted on in Banff; a weiner roast in June and reports from convention delegates with Misses Pullen and Smith as special guests. Mrs. M. Walker who has guided the Baby Clinic through a busy and successful year left the community in June and will be greatly missed by members and mothers.

District 3

Olds

At the June meeting of the chapter, Mrs. N. Herbig, one of the two delegates to the C.N.A. biennial convention in Banff, gave a most interesting report on the highlights, the splendid addresses and the many social activities, of which the Western dinner attended by 1200 nurses in western costume was the most hilarious.

District 4

Medicine Hat

A more active year is noted in a summary of the district's activities and a telephone committee, newspaper notices and radio announcements have aided greatly in maintaining an average attendance of 33 at the six meetings held since January. Chief business was making arrangements for the biennial convention in Banff. Other activities were: a dinner meeting with members of the graduating class as guests and Mr. L. Kohn entertaining with films of his trip abroad; the attendance of 70 nurses, including three of World War I in their service uniforms, at the re-dedication service in May; the address on Polio by Dr. J. M. Brown of the health unit; reports from the six delegates to the biennial convention; presentation of $100 to the school of nursing in appreciation of the use of the nurses' residence for meetings and social functions. The social service committee continues to provide nurses when required.

Officers for 1954 are: President, Mrs. R. McKay; vice-presidents, Mrs. A. Renner, J. L. Mogen; secretary, F. Ireland; treasurer, J. MacKay. Convener of social service committee is L. Greene.

District 7

Jasper

Mrs. D. Bonner presided at the June meeting of the chapter and Mrs. White, delegate to the C.N.A. Biennial Convention in Banff, read a stimulating report. M. Barry, Mmes Bonner and Siga assisted the hostess, G. Morin, in serving refreshments.

NEW BRUNSWICK

Woodstock

Mrs. P. Raymond, president, chaired a recent regular meeting of the chapter attended by 22 members. The retiring secretary-treasurer, H. Hull, gave the annual report and other reports were submitted by

Mrs. D. Fisher and P. Jackson. New officers elected are: President, H. Salmon; vice-president, Mrs. H. Montgomery; secretary-treasurer, Mrs. R. McGee; in other capacities, G. Charters, P. Jackson, E. Warman, G. Craig, Mmes W. Adair, K. Hamilton, D. Fisher, B. Gardiner. Miss Charters was appointed delegate to the annual convention in Edmundston, an invitation to the graduation exercises and reception was accepted, plans for the annual picnic were made and a vote of thanks was extended to the retiring president. Serving refreshments were: Mmes Aiton, McIntosh, Chesnut, and Lanyon.

NOVA SCOTIA

HALIFAX

The Maritime Council of Catholic Nurses held their annual two-day convention in June at the Infirmary nurses' residence. Dr. F. J. Barton of Dartmouth in his address, "Recent Surgical Advances," remarked on the tremendous strides the nursing profession had made hand in hand with medicine and surgery and B. MacDougall presented a paper on "The Catholic Nurse in the Community." Following various committee reports, Mrs. M. Pittard was made delegate to the International Congress of Catholic Nurses at Quebec and the president, Mrs. A. MacDonald, also planned to attend. A council comprising the president, past president, L. Grady and two clergymen was appointed to study the possibility of affiliating with the Canadian National Association of Catholic Nurses. Later the delegates were entertained at tea by the sisters when a program by children of St. Joseph's Orphanage, directed by Mrs. B. Inglis, was presented. Next year the convention will be held at the new St. Elizabeth's Hospital in North Sydney.

NEW GLASGOW

B. Duff, singing Langston Miller's song on Nova Scotia, opened the program at a recent meeting of the Registered Nurses' Association and Mrs. J. MacPherson, president, presented the guest speaker, John Fisher, CBC commentator, with a set of hand-tooled bookends made by Raymond Mole. Mr. Fisher's sallies and countless stories interpolated with many colorful and interesting facts about Canada and Canadians from coast to coast provided excellent entertainment. He urged a greater sense of humor on all in dealing with each other or those outside — especially the development of our ability to laugh at ourselves and our differences — and an increased national pride. When tea was served, it was announced that nearly $150 had been raised for W. Callow, an old friend of the speaker.

ONTARIO

DISTRICT 1

LEAMINGTON

The June meeting of the Nurses' Association took the form of a pot-luck supper and about 18 members attended. Mrs. N. Prit-

chard, vice-president, took the chair and will remain as president for the coming year, replacing Mrs. F. Sherlock who has resigned due to ill health while Mrs. S. Roberts was nominated as vice-president. $100 was voted to the new Recreation Centre, and it was decided to bestow an annual scholarship of $150 on a worthy student wishing to enter the nursing profession.

PETROLIA

Thirty-two nurses attended the final district meeting of the summer season and the treasurer reported that over half the money for a new obstetrical table at the C.E.E. hospital had been raised. The annual bake sale and talent table were planned for November and the hope for an appearance of the Polymer Glee Club after the first of the year was expressed. Games and a strawberry social followed.

DISTRICT 3

INGERSOLL

A recent meeting of the district took the form of a Crazy Hat show and members wore creations featuring everything imaginable including radishes, asparagus and kitchen cutlery. Among the most outstanding were hats worn by A. Lawrence, Mmes J. Milne, C. Pittock, J. Meatherall, H. MacKay, F. Newman, J. Ferguson, C. Wilson, A. Walters, C. Holland and M. Christie.

WINGHAM

General Hospital

At the business meeting of the Graduate Nurses' Association conducted at the annual picnic Mrs. W. Ringrose, president, was in the chair and it was decided to hold the picnic next year at Kincardine Beach on June 30. Correspondence from members unable to attend was read and Mrs. Stark (nee Imlay) of Detroit was welcomed. The election of officers under the chairmanship of Mrs. R. Lloyd resulted as follows: Honorary president, Mrs. G. Gillespie; past president, Mrs. R. Lloyd; president, Mrs. W. Ringrose; secretary-treasurer, Mrs. N. MacDonald; in other capacities, Mmes S. Gallaher, S. Moffat, B. Walden, C. Finlay, D. McKenzie. A presentation and vote of thanks were made to Mrs. MacDonald. Contests and prizes preceded the picnic lunch.

DISTRICT 4

NIAGARA

A picnic sponsored by the chapter in June in honor of the graduating classes of Greater Niagara General and St. Catharines General Hospitals was well attended. The business meeting that followed was conducted by R. Brown.

DISTRICT 5

TORONTO

St. Michael's Hospital

May 26 was an eventful and happy day for 25 preliminary students who received their caps. The ceremony was held in the hospital chapel which was filled with parents, relatives and friends of the students. A reception followed in the main residence. C. Hennessy has joined the staff at Kimberley Public Hospital, B.C. and D. Dunlop that of Providence Hospital, Moose Jaw, while V. Beausoleil is taking a course in neurosurgical nursing at the Montreal Neurological Institute.

District 10

Fort William

The graduating classes of the three Lakehead hospitals were entertained at a dinner in the Royal Edward Hotel.

Port Arthur

St. Joseph's Hospital

Proceeds of a St. Patrick's tea sponsored by the student nurses' association were used to send two student nurses, H. Birck and P. Kennelly, to the C.N.A. biennial convention in Banff.

District 12

Timmins

St. Mary's Hospital

At the closing meeting of the season of the alumnae association conducted by the president, Mrs. R. Ashenhurst, reports on the graduation dance were submitted and final details of the Silver Jubilee program booklet were discussed.

PRINCE EDWARD ISLAND

Charlottetown

Sr. M. Irene, president of Charlottetown Chapter, conducted a joint meeting of the chapter and that of Summerside at the picnic at Cavendish National Park when the following nurses gave reports on various aspects of the C.N.A. biennial convention in Banff: M. Archibald, V. Darrach, E. Hume, E. Enman, and M. Thompson. Forty-five nurses attended and Mrs. L. MacDonald spoke on her impressions of the Maritime Hospital Association meeting in St. Andrews while K. MacLennan reported on that of the Canadian Tuberculosis Association.

QUEBEC

Montreal

The first three Canadian Army nurses of an advance party of 28 more now training in Canada and due for duty later this year at the British Military Hospital at Iserlohn, Germany, left London for Germany in June accompanied by Medical Officer Capt. J. Hamshire of Kingston, Ont. They are the first nurses to be posted to Europe since World War II. Lieuts. R. Roy and S. Pellissier are Montrealers while Capt. (Matron) H. Sloan is from Saskatoon. The hospital serves all British troops in Germany and the 1st Canadian Infantry Brigade Group at Soest.

Royal Victoria Hospital

Preliminary students received their caps and were entertained at tea in July. H. Lamont, G. Yeats, G. Purcell, R. Fleming and A. Farley attended the C.N.A. Biennial Convention in Banff and reported a thoroughly interesting and entertaining time. Lieut. C. Lambertus, RCN, has been transferred from Moncton to Halifax. J. (Morrison) Hutton has been made secretary of the Moncton Chapter of the alumnae association replacing D. (Rice) Storer.

Positions Vacant

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

Supt. of Nurses for modern 60-bed General Hospital. Apply, stating qualifications, Dr. M. R. Stalker, Honorary Medical Supt., Barrie Memorial Hospital, Ormstown, Que.

Asst. Supt. for active 60-bed General Hospital. Some training in Instruction would be preferable. Apply, stating qualifications & salary expected, Supt., General Hospital, Strathroy, Ontario.

Science Instructor for Sept. Complete maintenance in comfortable suite. 120-bed hospital — 35 students. New 150-bed hospital under construction. Apply, stating experience & salary expected, Director of Nurses, Jeffery Hale's Hospital, Quebec City, Quebec.

Instructors for: Science Teaching followed by Clinical Ward Teaching; Clinical Ward Teaching & lectures in Medical Nursing. Commencing salary: $250 (additional for experience). Current R.N.A.B.C. contract in effect. 65 students; one class per yr. For information about position & community apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Nursing Arts Instructor for School of Nursing. 150 students—450-bed hospital. Apply Director of Nursing, General Hospital, Saint John, N.B.

Director of Nursing Services for modern, well equipped & staffed 82-bed hospital. No training school. On staff we have a dietitian, pharmacist, accountant, medical records librarian & admitting officer. Your duties will therefore be primarily supervision of nursing services. Salary: $325-350 per mo. Apply, enclosing references & stating qualifications & experience, Supt., Union Hospital, Canora, Sask.

Director of Nursing for 100-bed hospital. Apply Supt., Norfolk General Hospital, Simcoe, Ont.

General Supervisors, Charge Nurses & General Duty Nurses for new 150-bed hospital. Starting salary for General Duty Nurses — $220 for B.C. Registered, with annual increases up to $30. 40-hr. wk. 1½ days cumulative sick leave. 28 days vacation. 11 statutory holidays. Apply Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

Obstetrical Supervisor for 70-bed General Hospital. Salary: $200 per mo. & up, depending on qualifications. Good personnel policies. Apply Supt., Ross Memorial Hospital, Lindsay, Ontario.

Dietitian (qualified) for Teaching Hospital. Opportunity for advancement. Full maintenance. Fare from Canada for accepted candidate. For full particulars, write, giving qualifications & date available, Matron, King Edward VII Memorial Hospital, Bermuda.

Nurse Technician Team (intravenous & intramuscular therapy). Apply Dr. H. Featherston, Asst. Supt., Civic Hospital, Ottawa, Ontario.

Public Health Nurse for Health Unit for generalized program. Proximity to Toronto permits urban living conditions to be combined with rural-urban work. Excellent transportation arrangements, group insurance & other attractive working conditions. Apply Dr. R. M. King, York County Health Unit, Newmarket, Ont.

Public Health Nurse for Town of Deep River, Ont. Salary: $2,900-3,120 depending on qualifications. Pension, medical & vacation plans. Living accommodations in staff hotel. State all details including age, marital status, education & experience in first letter to "File 7D," Atomic Energy of Canada Ltd., Chalk River, Ont.

Operating Room Supervisor for 220-bed hospital. Salary dependent on qualifications. Apply Director of Nurses, Grace Hospital, Winnipeg, Man.

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada,
193 Sparks Street, Ottawa 4, Ont.

If you are coming to Britain to nurse, you will be welcome at 324-bed Sully Hospital, Sully, Glamorgan, South Wales. Modern hospital on the sea. Experience available in Medical & Surgical Nursing of all Chest Diseases in adults & children. Post-graduate course for British Tuberculosis Ass'n Certificate & instruction by medical staff & tutor. Comfortable, modern nurses' home with recreational facilities. For further information write H. M. Foreman, M.B.E., M.B., Physician Supt.

General Duty Nurses — "You will like it here." Placement in the service of your choice in Teaching Hospital. Beginning salary: $240 per mo. for 40-hr. wk. Scheduled increases, payment for overtime, 6-hr. evening duty. $270 per mo. for night duty. Sick leave, 6 holidays, 3 wks. vacation. Residence facilities if desired. Tuition-free courses after 6 mos. service. Opportunities for advancement. Apply Director of Nursing Service, University Hospitals of Cleveland, Cleveland 6, Ohio.

General Duty Nurses. Gross salary: $200 per mo. with 1 yr. or more of experience; $190 per mo. with less than 1 yr. experience; $20 per mo. bonus for evening or night duty. Annual increment, $10 per mo. 44-hr. wk. 8 statutory holidays. 21 days vacation & 14 days sick leave with pay after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

Graduate Nurses for General Duty. Living-in accommodation if desired. Apply Supt of Nurses, Homewood Sanitarium, Guelph, Ont.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

General Duty Nurses. Salary: $182.43 (one hundred eighty-two dollars & forty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience, Matron, Terrace & District Hospital Terrace, British Columbia.

General Duty, Operating Room & Obstetrical Nurses. Salary: $200 for recent graduates Laundry. 8-hr. day, 44-hr. wk. — straight shift. $20 differential evenings — $15 nights. Vacation, sick time, statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Director of Nursing, General Hospital, Winnipeg, Man.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved. Student affiliation & post-graduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Duty Nurses for 110-bed hospital in scenic Fraser Valley, 65 miles east of Vancouver on Trans-Canada Highway. Salaries, holidays, etc., in accordance with R.N.A.B.C. personnel practices. Residence accommodation available. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

THE QUEEN ELIZABETH HOSPITAL OF MONTREAL

REQUIRES IMMEDIATELY

a) A Clinical Supervisor for Medicine and Surgery (90 beds).

b) An Obstetrical Supervisor (26 beds).

POST GRADUATE COURSE REQUIRED;

GOOD SALARY & PERSONNEL POLICIES.

Apply:

DIRECTOR OF NURSING, QUEEN ELIZABETH HOSPITAL OF MONTREAL, 2100 MARLOWE AVENUE, MONTREAL 28, QUEBEC

General Duty Nurse for 17-bed hospital, about 100 miles from Calgary. Salary: $170 with full maintenance. Increase of $5.00 per mo. after each 6 mos. service up to 3 increases. Transportation refunded after 6 mos. service. Usual vacation & statutory holidays. Apply Municipal Hospital, Elnora, Alta.

Graduate Nurses (3) at once owing to present nursing staff leaving to get married. 30-bed hospital on C.P.R. main line & Trans-Canada Highway, 2 hrs. from Calgary. Modern nurses' residence & garage. 8-hr. day, 6-day wk. with rotating shifts. Starting salary: $170. $5.00 increase at end of each 6 mos. 3 wks. holiday & statutory holidays. Sick leave with pay & free hospitalization. Apply Matron, Municipal Hospital, Bassano, Alberta.

General Duty Nurses for 67-bed General Hospital. Gross salary: $200-$220 per mo. with $10 & $15 per mo. increments for night & evening duty respectively. 44-hr. wk. Apply Supt., Portage Hospital District Area 18, Portage la Prairie, Man.

General Duty Nurses for 430-bed hospital. Salary: $230-260. Credit for past experience. Annual increments. 40-hr. wk. Statutory holidays; 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Registered Nurses (2) for General Duty. 40-bed Municipal Hospital. Starting salary: $180 per mo. plus full maintenance to maximum $220 according to nursing experience. $5.00 per wk. extra for night duty. 44-hr. wk. 3 wks. holiday with full pay after 1 yr. service. Statutory holidays. Modern nurses' home on grounds. Apply Sec., Municipal Hospital, Box 560, Taber, Alta.

Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Registered Nurses for new 30-bed hospital. R.N.A.B.C. policies in effect. Apply Matron Creston Valley Hospital, Creston, B.C.

Registered Nurses for General Duty in small General Hospital in town of Huntingdon, 45 miles southwest of Montreal, with excellent bus service to that city. Pleasant working conditions. 8-hr. duty with three rotating shifts. Salary: $150 per mo. with full maintenance & three increases of $5.00 per mo. semi-annually. BX paid. 1 mo. paid vacation after 1 year. Apply Matron, County Hospital, Huntingdon, Que.

Registered Nurses for General Duty (2) for 30-bed hospital, Dryden, northwestern Ontario. Fully modern nurses' residence. Salary: $160 per mo. plus full maintenance. Salary subject to increase after 6 mos. with regular annual increases thereafter. 30 days vacation after 1 yr. service. Successful applicants reimbursed rail fare after 1 yr. Apply, stating age & when available, Supt., District General Hospital, Dryden, Ont.

Registered Nurses for 82-bed hospital. Gross salary: $210-230 per mo. 8-hr. day — no split shifts; 6-day wk. Rotating shifts. 30 days holiday with pay after 1 yr. service & all statutory holidays. Apply Supt. of Nurses, Union Hospital, Canora, Sask.

McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONTARIO

Offers

Career Positions to Graduate Nurses qualified as:

OBSTETRICAL SUPERVISOR
SCIENCE INSTRUCTRESS
CLINICAL INSTRUCTRESSES

Salaries commensurate with experience; 28 days vacation; 8 statutory holidays. Sick leave accumulative to 60 days. Hospitalization benefits; residence accommodation; transportation refunded. New, Modern, well equipped and staffed 435-bed Hospital.

APPLY DIRECTOR OF NURSING

Public Health Nurses (25) & vacancies for staff appointments (5) in North York (adjacent to Toronto), due to population increase of 75,000 in 5 yrs. Starting salary for experienced successful applicants: $3,520 including car allowance. Generalized program. 35-hr. wk. 4 wks. vacation with salary; cumulative sick leave. Free hospitalization insurance; pension plan; group life insurance. Small suburban districts are available. Address inquiries to Dr. Carl E. Hill, Medical Officer of Health, 5248 Yonge St., Willowdale, Ont., & interviews can be arranged before October or November appointments.

Registered Nurses for General Duty for active 50-bed General Hospital, 100 miles northwest of Toronto. Attractive salary plus full maintenance. Attractive living accommodation. Apply Supt., Memorial Hospital, Listowel, Ont.

If you are coming to Britain to nurse, you will be welcome at 240-bed Glan Ely Hospital (Pulmonary & Non-Pulmonary), Fairwater, Cardiff, South Wales. **Female Staff Nurses (S.R.N.)** — excellent experience available in bone & joint surgery & thoracic surgery. British Tuberculosis Ass'n Certificate may be obtained after 12 mos. service. **Female Student Nurses** for B.T.A. Cert. **Pupil Asst. Nurses** for Training School inaugurated with two local hospitals. All posts resident or non-resident. The attention of applicants is drawn to the prior need for applying to the General Nursing Council to be placed on the English Register. For further particulars write Matron.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Senior District Supervisor for City of Ottawa. Generalized public health nursing program under director of public health nursing. Blue Cross benefits & pension fund. Salary range: $3,060-3,990 plus cost-of-living bonus of approximately $22 per mo. Salary commensurate with experience. Apply Employment & Labour Registry, Room 118, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

Operating Room Nurses. An interesting variety of experience is available to operating room nurses at the Montreal General Hospital. For further information, apply Director of Nursing, General Hospital, 60 Dorchester St. E., Montreal 18, Que.

Registered Nurses (2 or 3) for General Duty 18-bed hospital in beautiful Windermere Valley, B.C. Separate nurses' residence, fully modern. Salary: $220 per mo. less $50 full maintenance, subject to semi-annual increases. 28 days vacation after 1 yr. service; 2 wks. vacation at end of 6 mos. If desired, statutory holidays & 18 days sick leave per yr. cumulative. 8-hr. alternating shifts; 40-hr. wk. Good swimming, fishing, hiking; near radium hot springs; new modern theatre. Apply, stating age & when available, Mrs. D. Cookson, Matron, Lady Elizabeth Bruce Memorial Hospital, Invermere, B.C.

General Duty Nurses (4) — Registered or Graduate — for 45-bed hospital. 8-hr. shift; 48-hr. wk. Salary: $210 per mo. gross. Increase of $5.00 per mo. after 6 mos. service. 3 wks. holiday with pay after 1 yr. service. Modern nurses' residence. Transportation refunded. Daily bus facilities to North Battleford & Saskatoon. Apply Matron, Union Hospital, Meadow Lake, Sask.

VANCOUVER GENERAL HOSPITAL

The Vancouver General Hospital requires:

General Staff Nurses. 40-hr. week. Salary of $231.00 as minimum and $268.50 as maximum, plus shift differential for evening and night duty.

New ***Paediatric Unit*** now open. Applications from qualified **Paediatric Nurses** welcome.

Residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

Supervisor to organize Medical Dept. in new Teaching Hospital. Good salary & personnel policies. Apply Director of Nursing, University Hospital, Saskatoon, Sask.

Supervisors: Evening (1); Night (1); Operating Room (1). 86-bed General Hospital. Pleasant living conditions. Prettiest town in Manitoba. Salary open. Apply Supt. of Nurses, General Hospital, Dauphin, Man.

Laboratory Technician for hospital in southwestern Ontario. Salary commensurate with training. Apply, stating age & experience, c/o Box E, The Canadian Nurse, 1522 Sherbrooke St. W., Montreal 25, Que.

Staff Nurses for 600-bed General Hospital with School of Nursing. Salary: $273-322. Shift & education differentials. 40-hr. wk. 12 holidays; cumulative sick leave; 3 wks. vacation. Apply Director of Nursing Service, General Hospital, Fresno, California.

Registered Nurses for General Duty & Operating Room. Busy 70-bed hospital. Commencing salary: $180 & up. Good personnel policies. Apply Supt., Ross Memorial Hospital, Lindsay, Ont.

Registered Nurse for 14-bed hospital. Modern equipment. Pleasantly located. Salary: $110 per mo. clear. 1 mo. vacation annually. Apply Supt., Grand Manan Hospital, Grand Manan, N.B.

Public Health Nurses for generalized program — City of Ottawa Health Dept. Salary: $2,460-3,222 plus cost of living bonus (approx. $260 per yr.). Good personnel policies. Superannuation & Blue Cross benefits. Apply Employment & Labour Registry Office, Room 118, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

Day Supervisor: 8-8. Own private suite. 32-bed General Hospital. Apply Supt., Ajax & Pickering General Hospital, Ajax, Ont.

Operating Room Nurse to act as Asst. Charge Nurse immediately for 100-bed Children's Hospital. Post-graduate course or previous operating room experience required. For information regarding salary & policies, apply Director of Nursing, Children's Hospital, 250 West 59th Ave., Vancouver 15, B.C.

Staff Nurses for 40-bed General Hospital, 55 miles from Toronto. Straight 8-hr. day with rotations if necessary. Salary: $200 less $30 for full maintenance. Apply Supt., Stevenson Memorial Hospital, Alliston, Ont.

Nurse to direct Public Health Nursing program for Health Dept. of City of Calgary. Preference given to person holding degree or certificate in public health nursing with administrative & supervisory experience. 5-day wk. Sick leave & pension plan. 1 mo. holiday after 1 yr. Car provided. State salary expected. Apply Dr. W. H. Hill, City Health Dept., Calgary, Alta.

GENERAL STAFF NURSES

GENERAL WARDS **OPERATING ROOM** **OBSTETRICS**

for

200-bed hospital

Pleasant city of 33,000. Two colleges.
Good salary and personnel policy.

For further information apply to:

DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO.

Night Supervisor (1) also Charge Nurse (1) at once for General Ward at the Country Branch of The Hospital for Sick Children. 44-hr. wk. Live in. Usual holidays with pay, sick leave, etc. Transportation provided to & from city. Telephone Toronto CHerry 1-5266 or write Supervisor, The Hospital for Sick Children, Thistletown, Ont.

Public Health Nurse for generalized program with Bruce County Health Unit. Minimum salary: $2,550 with allowance for experience. Pension & Blue Cross plans available. 4 wks. vacation. Car provided if required. Apply T. H. Alton, Sec.-Treas., Bruce Co. Health Unit, Walkerton, Ont.

Registered Nurses for 38-bed general hospital. Salary: $255. Periodic increases. Excellent personnel policies. For further information, contact Supt. of Nurses, Red Wing Hospital, Red Wing, Minnesota.

Graduate Nurses for General Duty. Rotative shift. 44-hr. wk. Excellent working conditions & personnel policies. Apply Director of Nursing, South Waterloo Memorial Hospital, Inc., Galt, Ont.

Charge Nurse and Supervisory Positions are available for Registered Nurses at Manitoba Sanatorium, Ninette, Man. Extensive chest surgery provides interesting work & worthwhile experience. Salary range: $220-265 per mo. depending on qualifications & appointment. Board, room & laundry supplied for $45 per mo. Comfortable quarters in new nurses' residence. Generous vacation, group insurance, all statutory holidays & other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Man.

Registered Nurses (2) for General Duty in 18-bed hospital. Salary: $220; $5.00 increment every 6 mo. Full maintenance $40 per mo. 5½-day wk. Apply Matron, Lady Minto Hospital, Ganges, British Columbia.

Public Health Nurses for generalized program in Township of Etobicoke (Toronto suburb). Minimum salary: $2,800. Allowance made for experience. Transportation allowance provided. Apply Medical Officer of Health, Township of Etobicoke, 4946 Dundas St. W., Toronto 18, Ont.

Public Health Nurse for educational program & follow-up work of Ottawa Branch — Canadian Cancer Society & Ottawa Civic Clinic — Ontario Cancer Foundation. Salary: $225 per mo. plus cost-of-living bonus. Pension plan available. Preferably bilingual. Please state all details including age, marital status, education & experience when applying to Dr T. G. Stoddart, Civic Hospital, Ottawa, Ont.

Registered Nurse with Operating Room Training, particularly in Thoracic Surgery. Apply V. J. Manders, Supt. of Nurses, Ongwanada Sanatorium, Kingston, Ont.

Night Supervisor for 50-bed hospital. Good Salary; full maintenance in new Nurses' Residence. Apply W. A. Oakes, Clinton, Ont.

HOSPITAL NURSES

GRADE 1 — $2,430-$2,820 GRADE 2 — $2,730-$3,120

Department of Veterans Affairs Hospitals

Camp Hill, Halifax	Deer Lodge, Winnipeg
Ste. Anne's, Montreal	Veterans Hospital, Saskatoon
Sunnybrook, Toronto	Colonel Belcher, Calgary
Westminster, London	Shaughnessy, Vancouver

Application forms, available at your nearest Civil Service Commission Office, National Employment Office or Post Office, should be filed with The Civil Service Commission, Ottawa.

CIVIL SERVICE OF CANADA

Assistant Director of Nursing Service and Education, qualified, for 350-bed hospital. Personnel policies based on R.N.A.O. recommendations. For further details apply Director of Nursing Education and Nursing Service, General Hospital, Port Arthur, Ont.

General Duty Nurses for 50-bed modern hospital in clean, progressive mountain town. Salary $200 per mo. with meals and uniform laundry; $5.00 per mo. increase every six mos. for 2½ yrs.; $10.00 extra for afternoons and nights. Duplex apartments on hospital grounds available. For information write The Cody Hospital, Cody, Wyoming, U.S.A.

Nurse Instructors, eligible for registration in B.C. Salary $255-287 per mo. Post Graduate training in psychiatric nursing, preferably teaching experience in a psychiatric hospital. Apply Personnel Officer, B.C. Civil Service, Essondale, B.C.

Public Health Nurse — Grade I — British Columbia Civil Service, Dept. of Health & Welfare. Starting salary: $255-260-266 per mo. depending on experience, rising to $298. Promotional opportunities available. Candidate must be eligible for registration in B.C. & have completed University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of province.) Cars are provided. 5-day wk. in most districts; uniform allowance; candidates must be British subjects under 40, except in case of ex-service women who are given preference. Further information may be obtained from Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C. Application forms obtainable from all Govt. agencies, Civil Service Commission, Weiler Bldg., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Victoria, B.C.

General Duty Nurses (2) — one each for Oct. & Nov. Salary: $180 per mo. plus full maintenance. 3 increases of $5.00 per mo. for each yr. experience to a maximum of $195. 3 wks. holiday with pay plus all statutory holidays. Separate nurses' residence. Apply Matron, Municipal Hospital, Fairview, Alta.

Registered General Duty Nurses (2), 76-bed hospital. Salary $220 per mo. $5.00 per mo. increase after 6 mos. service; 40-hr. wk; 2 wks. vacation and holidays with pay after one yr. Nice college town. Apply Director of Nursing Service, Jamestown Hospital, Jamestown, North Dakota.

Graduate Nurses offered a six-month post-graduate course in Tuberculosis. Maintenance and salary as for general staff nurses; opportunity for permanent employment if desired. Spring and fall classes. For further information apply Baker Memorial Sanatorium, Calgary, Alberta.

Registered Nurse with Public Health qualifications to start immediately at the Stony Plain — Lac Ste. Anne Health Unit No. 17, near Edmonton, Alta. Minimum salary $2,640 p.a. and increments $410 x 3 and $260 x 1. Starting salary by arrangement. Applications stating qualifications to Director of the Health Unit, Stony Plain, Alberta.

Graduate Nurses for General Floor Duty; 44-hr. wk., rotating shifts; new 163-bed Sanatorium. Modern nurses' residence; liberal personnel policies; salary open. Write Mrs. R. MacMillan, R.N., Supt. of Nurses, Sudbury & Algoma Sanatorium, Sudbury, Ontario.

Love your Neighbors

We cannot too often tell ourselves that our essential business is to learn to love our neighbors. Meeting our neighbors may bring annoyance and even pain at first. Many of them are queer, and have rough exteriors, and even grave faults. At first we may come back from such contacts irritated and upset; then seclusion begins to look rather attractive. But as we go on meeting our neighbors, we make wonderful discoveries. When they have got over their first instinctive dislike of us, they begin to show us other aspects of themselves. Their views may be to our minds outrageous, but their hearts are generally warm. Their morals may be imperfect, like ours, but they remain people of worth, and often have interesting powers and gifts. Good fellows! Fine women! And when we have made these discoveries, contact with our neighbors is seen to be the privilege and the joy which it really is.

— A. Herbert Gray, D.D.
The Secret of Inward Peace